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COMMISSION ON ORGANIZATION OF THE
EXECUTIVE BRANCH OF THE GOVERNMENT



APPENDIX G

# REPORT OF THE SUBCOMMITTEE ON MEDICAL MANPOWER COMMITTEE ON FEDERAL MEDICAL SERVICES



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November 1948

U.S. COMMISSION ON ORGANIZATION OF THE
EXECUTIVE BRANCH OF THE GOVERNMENT.

Committee on Federal Medical Services.

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Note: A single copy of appendix material which supports this report and to which reference is made throughout is on file in the offices of the Medical Services Committee.

SUBCOMMITTEE ON MEDICAL MANPOWER

Definitions and Assumptions

Certain basic functions make it necessary that the Federal Government assume a direct responsibility for providing health and medical service. The duty of providing this service is delegated to an appropriate agency as an operational task. The naming of the beneficiaries who are to receive the medical service and the designation of the agency responsible for each class of beneficiary is by legislative act of Congress.

The conditions that determine legislative action regarding medical service are:

1. That the nature of some primary function in government requires that supporting health and medical service be provided;

2. That the workload placed upon an agency is identified with its primary task, or at least does not impose a duty that might divert the agency from meeting its primary responsibility or impede it from reaching its goal;

3. That funds are appropriated to implement the operational plans and needs of the agency that is assigned the responsibility; and

4. That resources other than funds are available to the agency to carry out its task.

At the present time no single agency of the Federal Government has the manpower resources in sight to enable it to meet its responsibilities of providing health and medical service. Furthermore, this critical situation cannot be regarded either as temporary or self

correcting. Vigorous measures taken to meet the situation have been initiated during the past three years by single agencies and by joint action of agencies, but the results have been fragmentary and temporary. When partially effective, as in the case of the Veterans Administration (P.L. 293), the improvement in the position of one agency has been achieved only at the risk of detracting from the position of others. The armed forces have been able to meet their responsibilities only by the obligatory service of trainees inducted during the war years.

No significant attempt has been made to consider the predicament as a whole. It is timely therefore, for the Medical Services Committee to measure the manpower demands of all agencies against the many factors that determine whether of not these demands can be satisfied by current methods from the resources that exist. Careful appraisal must be made of corrective measures short of changes in organization, recognizing the pitfall of attributing failure in operation to the design of the machine. If changes in organization are considered necessary, it is important to indicate their nature and the implications they may have relative to the primary objectives of the agencies concerned.

There are certain assumptions and considerations peculiar to manpower that are non-existent or of less importance in an analysis of demands and resources that relate to materiel. More precisely drawn definitions are required to distinguish the proper boundaries of governmental authority and function. Health and medical service is a basic requirement of all the people and governmental agencies seeking to provide this service to a selected group of beneficiaries

must draw on the same manpower pool that supplies the needs of the nation as a whole. The doctor -- the term is used in the broad sense of the individual who supplies medical service -- is a national asset. At the same time, the doctor is a citizen, and has just claim to the rights and privileges of other citizens and the same freedom from governmental authority or sanctions.

In a complex and highly technical field such as that concerned with health and medical service, judgments as to whether a task can be undertaken or a demand satisfied inevitably involve quality as well as quantity. The quality of medical service provided by an agency of government will determine whether medicine as a supporting service actually expedites and aids the primary purpose of the agency. This in one instance may be to ameliorate the distress of a veteran or in another to insure that the plans of a military commander are not frustrated by epidemic disease.

Judgments of a value such as quality are vulnerable when based on subjective premises, so objective frames of reference are required. It is assumed, for example, that in order to attain its objectives, medical service provided by the Federal Government needs to be equal in quality to the general average of that provided by non-governmental agencies; it must meet the standards attained by the armed forces in World War II; it must in all agencies be equal to that provided by the Veterans Administration insofar as the program of this agency has been fully realized. (See footnote on page 7.)

Quality in medical service is derived from an integration of general medical care with those specialized skills attained only by specialist

services. In fact, technical skill and competence in medicine are synonymous with specialization, exactly as is the case in all other fields that bring expert knowledge and experience to bear on practical affairs.

It may be assumed therefore, that when a governmental agency classifies its roster of medical personnel in terms of specialists and general duty officers and lists it personnel requirements by categories of specialists, that the agency is giving due consideration to the quality of the medical service it seeks to provide. Its failure to meet its requirements can thus be measured both in quality and quantity. It might also be assumed that measures proposed to correct personnel shortages will be phrased in terms that give due consideration to the procurement of specialists. The effectiveness of corrective measures can thus be judged by determining whether they are likely to provide both the qualitative and quantitative necessities of medical service.

Considerations of quality in both general and specialized medical service become paramount when exploration of the manpower problem leads to the proposal that is commonplace when materiel is in short supply -- viz., increase the supply to meet the demand. For over half a century the medical profession has pursued a consistent policy directed toward keeping educational standards abreast of increasing medical knowledge. When educational advances have been tested and proven by experience, they have been codified in State law. Any attempt to bend this massive educational structure to meet the needs of an emergency short of war by measures that in any way jeopardize the standards that have been erected will meet firm resistance and require prolonged negotiation.

Here also the time-lag encountered before measures to increase supply can possibly yield significant results in available personnel comes into play and makes this a program for long-range planning.

It might be tempting for a subcommittee on manpower to present detailed considerations of pay, promotion, retirement and other technical aspects of personnel management that are intra-agency affairs. As these are governed by laws, policies and regulations that are closely identified with long experience of the agency in discharging the primary responsibility delegated to it, our competence in such considerations would be open to question and any conclusions controversial.

These matters may be excluded in order to concentrate on the major and clearly discernible manpower problems that confront all agencies. If a common denominator can be found for these problems, details can be passed over. The urgent problems are those that underlie personnel procurement. Medical service judged vital to certain functions of government when the manpower to provide it was available, and distributed among agencies and departments on this same assumption, is now unable to secure requisite manpower.

Failure in personnel procurement is a symptom that may or may not be significant. It may, under certain conditions, respond to what is known in medical terminology as symptomatic treatment. These measures include stimulation of recruitment efforts, adjustments of pay within reasonable limits, and elimination on the basis of careful work analysis of undesirable conditions that provoke resistance to recruitment. Time alone will correct certain self-limited and self-correcting procurement difficulties. Major readjustments in society such as those

that attend an economic depression or the outbreak of war may resolve procurement problems. In time of national emergency, procurement problems can be brushed aside by conscription.

When procurement difficulties persist after symptomatic remedies have been applied, and this is the present situation, it is possible to wait and do nothing or to invoke the authority of the Federal Government in emergency legislation. Another course is to probe more deeply into the possibility of adjustment to manpower shortage by increased economy of utilization. This is an extraordinarily difficult area of exploration not only because the subject of medical service with its two facets of quality and quantity resists precise methods of analysis, but also because medical service as a government function is largely a supporting service and not a primary objective. Many policies and regulations that determine whether there is economy or extravagence in the utilization of medical manpower are dictated by the parent agency and not by the supporting department.

Corrective measures to relieve shortage of medical personnel may also be explored by seeking a reduction in workload that might bring the task into line with the resources that are available to perform it. This leads to an analysis of the workload as a whole and also of the manner in which existing organizational structure has divided the workload among a number of agencies. The workload of each agency can be examined against the prime needs of the agency for the supporting medical services with which it is equipped and on which it might base its minimum personnel requirements. This can also be considered in the light of the ability of the agency to recruit personnel by voluntary

methods and when this has failed, whether a primary function of government is jeopardized to the extent that the authority of conscriptive measures must need be invoked.

The subcommittee on manpower contends that exploration of the prolonged failure of the several federal agencies to obtain medical personnel leads ultimately to a consideration of the organizational structure within the frame of which government has authorized the provision of medical service. It also leads to a consideration of whether boundaries in function extended by government in building up the total workload of medical service, on the premise that resources in medical manpower were inexhaustible, can be maintained by indirect rather than direct means; and whether direct responsibility for further medical service, even that which is useful and in accord with national ideals, must be limited or postponed until there is demonstrated ability to provide it. Consideration of the boundaries of function of government needs no justification when agency requests are already at hand to extend the limits of use of authority by government.

> "It is not possible and may not be desirable, to find a universally accepted definition of a qualified specialist. Certain specialty fields have been named by the Advisory Board for Medical Specialties and approved by the Council on Medical Education of the American Medical Association for the establishment of Specialty Boards that have a twofold purpose. One is to issue certificates to candidates who, after meeting specified training requirements, satisfactorily demonstrate their qualifications in an examination. The other purpose of the Boards is to improve opportunities for the training of specialists within the field concerned.
>
> The Advisory Board for Medical Specialties, as well as individual Boards, emphasize the positive educational nature of their program and specifically refrain from challenging, either directly or indirectly, the competence of physicians who base claims to specialist skills on grounds other than

"certification. As the Board movement has gained headway, however, and with the passage of time, certification has become a widely accepted objective criterion of specialist qualification. It has been used as such by the Veterans Administration and recognized by Congress in P.L. 293. It is used as a guide in the grading of specialists by the Surgeon General of the Army, and the professional graduate training (residency) programs of Army, Navy and Veterans Administration have been geared to meeting the standards of Specialty Boards. Requirements for specialists are expressed by both Army and Navy in terms of Board certified personnel.

It should be clearly understood therefore, that while in individual instances an agency or a single institution may recognize specialist competence on grounds other than certification, in dealing with the problem of quality care as a whole, the use of board certification as an index to the number of specialists on hand or in demand provides the only objective numerical basis for estimation of quality.

Attention is drawn to a commonly accepted method for extending the workload potential of a specialist or group of specialists through the apprentice system of training known as the resident training program. By maintaining supervisory control, a single specialist may delegate a large portion of the workload to apprentices and still assure a high standard of medical service. As men in training attain specialist skills, increments of the workload may be shifted to them as rapidly as they are judged competent to assume the responsibilities involved."

## PART I. INTRODUCTION

Introduction This report is not designed as a comprehensive analysis of all matters affecting federal medical personnel. Pay, promotion, retirement and other aspects of personnel management are subordinated to the central subject of manpower, which is interpreted as the procurement and retention of sufficient personnel with the necessary qualifications required to discharge the government's responsibilities in health activities. Aspects of administrative management are considered only where they affect the procurement, retention and utilization of personnel.

The categories of personnel considered herein at greatest length are physicians, dentists and nurses, and, in many instances, only physicians are discussed. This concentration is due principally to the need for brevity. It is justified, however, by the character of medical service staffing which gears the requirements for most categories of personnel to requirements for physicians, dentists and nurses, all of which tend to increase or decrease together. Shortages exist in many other categories and will be treated where significant. The probability that the Armed Forces will soon renew their request for Congressional authority to draft physicians and dentists, also creates a justifiable tendency to discuss medical personnel in terms of these categories.

Similarly this report is restricted largely to consideration of the largest five federal medical services, the Army, Air Force, Navy, Veterans' Administration and Public Health Service. Other

agencies, which account for less than two percent of medical personnel requirements, will be discussed when especially significant. It should be realized however that, regardless of size or relative success in procurement, all federal agencies are contending with the same basic forces in recruitment of professional personnel. Perhaps the most important of these forces is the financial return position of private practitioners who in 1947 had a median net earning of $8,744, an estimated increase of 137% over that of 1939 (survey by "Medical Economics," 1948). The median "take-home" pay of a Regular Army or Navy physician is $7,176.

The General Situation

Today the federal government employs the full-time equivalent 15,594 physicians, 3,221 dentists and 21,822 nurses, excluding those who provide intermittent, consultand and attending services. This is an increase in the case of physicians for example, of 83 percent over those employed in 1941. The categories at present comprise 8.2, 4.3, and 7.8 percent respectively of all physicians, dentists, and nurses estimated to be currently in active practice.

At present almost all agencies have shortages in virtually all categories of medical personnel. These shortages are especially serious among physicians, dentists and nurses, whose lengthy basic professional training is available only through non-federal institutions. Various measures have been taken to stimulate recruitment but none has been completely successful. Even in the Public Health Service, which is relatively popular among government agencies (See Appendix 50), and in the Veterans Administration where the professional personnel system was liberalized in 1946 to an extensive degree, substantial shortages still exist. In the latter agency more than 5,000 beds are unusable for lack of staff.

In the Armed Forces, the shortages have been even greater, necessitating special training programs, and special arrangements under which graduates of the ASTP and V-12 medical and dental programs were required to serve involuntarily. Most of these will have completed their service within the next year. During the same period, however, the Armed Forces will have been augmented through

this year's Selective Service Act by hundreds of thousands of men. Thus shortages of medical personnel will be created not only by attrition but by simultaneous increases in requirements.

As shown on the following page in Table I the greatest movement in the field of medicine today is toward federal employment. Assuming these estimates to be correct, the number of private practitioners is not keeping pace with growth in the population even though the total number of physicians has increased more rapidly. Due in large part or wholly to accelerated medical education programs during the war there are relatively more physicians in the country today than in 1941, but the proportionate increase has been drawn into full-time hospital service and into federal service rather than into private practice. If federal requirements are met during the next few years, with substantial increases planned in all agencies, and if upward trends continue in the requirements of industrial medicine, full-time hospital staffs, health departments and medical schools, it can be predicted that the ratio of private practitioners to civilian population will drop still lower. This ratio is now 1:1029 as compared with 1:988 in 1941. This perhaps should not be interpreted as a lowered level of medical attention, however, since intensified specialization, and expansion in full-time staffing of hospitals, represent shifts in the workload which alter the significance of the ratio.

TABLE I

PHYSICIANS IN THE UNITED STATES

By Employment Group

| | 1941 | 1948 | % Increase |
|---|---|---|---|
| Population 3/ | 131,261,214 | 144,614,000 | 10.2 |
| Physicians - Total | 176,000 1/ | 198,246 2/ | 12.6 |
| Private Practice | 132,908 | 140,515 | 5.7 |
| Full-Time in Hospitals | 16,400 | 22,383 | 36.5 |
| Industrial Medicine, Health Depts., etc. | 10,800 | 11,454 | 6.1 |
| Retired or Inactive | 7,392 | 8,300 | 12.3 |
| FEDERAL GOVERNMENT | 8,500 | 15,594 | 83.5 |

1/ Figures in this column are Public Health Service estimates based on A.M.A. data. Those retired are assumed to occur in the same proportion in 1941 as in 1948, i.e., 4.2% of total. (See Appendix 13)

2/ Estimates as of 15 February 1948 by Director Department, A.M.A. (See Appendix 13)

3/ Excludes Armed Forces: 1,460,000 in Army and in Air Force in 1941 and 1,000,000 in 1948; 338,786 in Navy and Marine Corps in 1941 and 500,000 in 1948.

TABLE II

FEDERAL AND NATIONAL MEDICAL

PERSONNEL AS OF JULY, 1948

Summary Table

| | Physicians | Dentists | Nurses |
|---|---|---|---|
| All Federal Agencies 1/ | 15,594 2/ | 3,221 2/ | 21,822 |
| Army and Air Force | 4,350 | 1,025 | 4,317 |
| Navy | 2,711 | 956 | 2,091 |
| Veterans Administration | 6,969 | 1,016 | 12,397 |
| Public Health Service | 1,289 | 202 | 1,951 |
| Indian Affairs | 95 | 13 | 480 |
| Other Agencies 3/ | 180 | 9 | 586 |
| National totals estimated to be in active practice 4/ | 189,946 5/ | 75,645 | 280,500 6/ |

1/ All salaried personnel are shown, both civilian and military. Salaried part-time personnel are shown in full-time equivalents. Per diem and fee-for-service personnel are shown elsewhere. Most data are for July 1, 1948, and other data are for the nearest date thereto.

2/ Residents and interns included.

3/ Figures for Other Agencies involve certain estimates and possibly certain duplications, but the error is not great enough to affect the totals significantly. See Appendix 4 for details of Other Agencies.

4/ Includes those in federal service.

5/ J.A.M.A., Estimate as of 15 February 1948.

6/ Computation for summer of 1948 by American Nurses Association.

Under present legislation and policies the Veterans Administration is now and may possibly remain the largest employer of federal medical personnel. Since the National Military Establishment is undergoing an earlier and more rapid expansion, however, and has less prospect of meeting its personnel deficit without changes in legislation or organization, its needs are considered first in this report. Of the three Armed Forces the Army is faced with the biggest problem in medical manpower.

## PART II. ARMY MANPOWER*

Workload The primary workload of the Army consists of provision of comprehensive medical care to 1,013,141 enlisted men and officers (Sept. 1948). Included in this strength is that of the Air Force (401,562) which has no organic medical corps of its own and no general hospitals. Included also are the troops overseas.

The workload carried by Army and Air Force Medical personnel is indicated by totals of 40,000 beds and 27,000 patients on June 30, 1948. During fiscal year 1948, there were 178,000 admissions to the 14 general hospitals and 95 station hospitals in the United States. Overseas admissions totalled 160,000. In the same year, more than 10 million out-patient treatments were reported.

Included in the above is the care of dependents and veterans. Lesser, though substantial, components of the workload are represented by induction and separation examinations, and by assignments to preventive medicine research, teaching and to duty with elements of the striking force. Induction examinations are now given largely by part-time civilian personnel. Due to personnel shortages, no attempt will be made to fill most medical positions in striking force units unless or until they are alerted.

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* Unless otherwise noted, references to Army in this section will include the Air Force.

Personnel 1/ Requirements: Quantity — The total strength of the Army and Air Force is planned to increase by almost fifty percent within the next twenty-one months. Most of this increase will occur in the Army, since the Air Force will engage to a lesser extent in the function of training new inductees.

Medical personnel is required in quantities consistent with this heavier workload but due to present shortages in professional categories, the numbers of physicians, dentists and nurses would have to increase to a much greater extent to meet the requirements stated. Such increases cannot be expected. In fact, due largely to completion by ASTP graduates of their obligated service, the Army predicts that during the next nine months losses of physicians will exceed gains by more than 1,000.

Physicians in the Medical Corps numbered 4,350 on 30 September 1948, of whom 2,550 were ASTP graduates. The last class of these men was called to duty this summer and will serve until the summer of 1950. Regular Army physicians number 1,205. Volunteers account for the remainder many of them being residents.

The Regular Army component is not such a stable personnel force as formerly. Almost 20% of this group were integrated during the past year. Simultaneous loss of 106 officers reduced the gain to a net of about 10%. Due to this flux, and to the fact that this group is only slightly larger than that of 1940 (1,164), when Army strength was less than a quarter of present strength, it is not expected that this component could be expanded to any significant degree under conditions which now prevail.

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1/ All figures for future Armed Force requirements are confidential and provisional.

TABLE 3

Requirements of Army and Air Force for Physicians

| | 30 Sept. 1948 | 31 Dec. 1948 | 30 June 1949 | 30 June 1950 |
|---|---|---|---|---|
| Total Strength | 1,016,900 | 1,099,900 | 1,350,000 | 1,475,000 |
| Physicians - | | | | |
| Gross Requirements | 6,880 | 7,279 | 8,461 | 9,208 |
| Less Mobile Striking Force 1/ | 972 | 972 | 972 | 1,050 |
| Less Requirements for Residents and Interns | 600 | 850 | 1,200 | 1,550 |
| Net Requirements | 5,308 | 5,457 | 6,289 | 6,608 |
| Retainable Strength 2/ | 4,350 3/ | 4,300 | 2,700 | --- |
| Expected Gains - | | | | |
| Volunteers | --- | 120 | 325 | --- |
| Civilians 4/ | 28 | 63 | 74 | --- |
| Drafted 5/ | --- | 10 | 50 | --- |
| Reassignments of Residents | --- | --- | 72 | --- |
| Expected Strength | 4,378 | 4,493 | 3,221 | --- |
| DEFICIT - AMOUNT | 930 | 964 | 3,068 | --- |

1/ The positions will not be filled until striking forces are alerted.
2/ Residents and interns are counted here as full-time personnel.
3/ This is the figure for 1 July 1948. No significant change occurred in subsequent three months.
4/ Part-time civilians are included in full-time equivalents.
5/ Under present Selective Service Act.

It may have been seen in Table 3 that if the Army is to continue its present medical functions, and if present methods for computing requirements for personnel are continued, the Army within nine months will need about twice as many physicians as it expects now to have. As of 30 June 1949 the expected availability of 3221 physicians must be compared with stated net requirements of 6,289. An additional 1,200 would be needed to fulfill present plans for the residency program in civilian hospitals.

The situation with respect to dentists and nurses is roughly comparable, although expected deficits have not been calculated in such detail. On 1 July 1948 there were 1,025 dentists, which was only a few more than half of the number then required. Of these only 650 are expected to remain in the Army until next July, when the net requirement will have risen to 2,788. This indicated deficit of about 75% would be reduced very little by the gains now predicted through volunteering.

The outlook for nurses is better only by comparison. As of 30 September 1948 there were 4,350 nurses for a net requirement of 5,971, a deficit of 27%. Even assuming that gains through volunteering will compensate for the losses of 650 which are predicted, 3,086 additional nurses would have to be recruited to fill the requirement of 7,436 calculated for 1 July 1949.

Personnel Requirements: Quality

In the previous section Army physician requirements were shown in total numbers. It is necessary to examine its personnel situation in terms of the special qualifications of those needed.

Before World War II the Medical Corps was composed largely of Regular Army men. Since this component was relatively stable, there was a distribution of these physicians among the various age groups, thus insuring a balance between the younger men and the older ones who had more, and more specialized, experience.

During the war the influx of civilians served to provide specialists in proportion to general duty men. Since the war, however, the Medical Corps has been composed largely of recently graduated ASTP physicians with virtually no special training and with relatively brief experience altogether. Their brief stay in the Army, plus the lack of any significant number of men recruited or integrated otherwise, has inhibited the growth of a fully qualified service.

Requirements and deficits in medical specialists are shown in the following tables.

TABLE IV

REQUIREMENTS IN ARMY AND AIR FORCE FOR MEDICAL SPECIALISTS

(Selected Specialists) 1/

| | Availabilities 2/ 1 July 1948 | Requirements 30 Sept. 1948 | 31 Dec. 1948 | 30 June 1949 | 30 June 1950 | Deficits 30 June 1950 |
|---|---|---|---|---|---|---|
| Total Specialists | 1808 | 2450 | 2575 | 2888 | 3015 | 1207 4/ |
| Surgery | 603 | 780 | 819 | 910 | 954 | 351 |
| Ortho-Surgery 3/ | (78) | (119) | (125) | (150) | (161) | (83) |
| Neuropsychiatry | 189 | 245 | 259 | 311 | 329 | 140 |
| Pediatrics | 113 | 104 | 109 | 124 | 130 | 17 |
| All Radiology | 133 | 113 | 119 | 133 | 134 | 1 |
| Cardiology | 3 | 31 | 33 | 39 | 41 | 38 |
| Other Specialists | 767 | 1177 | 1236 | 1371 | 1427 | 660 |

1/ For purposes of brevity only a few specialties are shown. They appear representative of the others in all respects. Other specialties are shown in the appendix.

2/ The availabilities of specialists are not expected to change radically in the near future, therefore they may be used for comparisons with requirements.

3/ Included in Surgery also. Not to be added.

4/ The total deficit will undoubtedly be much greater than this, due to the loss of an unpredictable number of ASTP specialists.

TABLE V

REQUIREMENTS IN ARMY AND AIR FORCE FOR MEDICAL SPECIALISTS

(Selected Specialist by Grade)

| | Availabilities 1 July 1948 | Requirements 30 June 1950 | Deficits 1/ 30 June 1950 | |
|---|---|---|---|---|
| Total Specialists | 1808 | 3015 | 1207 | 40% |
| B 2/ | 160 | 727 | 567 | 78% |
| C | 377 | 1343 | 966 | 72% |
| D | 1271 | 945 | -326 | (Surplus) |
| Surgery | 603 | 954 | 351 | 37% |
| B | 37 | 163 | 126 | 77% |
| C | 141 | 420 | 279 | 66% |
| D | 425 | 371 | -54 | (Surplus) |
| Ortho-Surgery 3/ | (78) | (161) | 83 | 52% |
| B | (6) | (30) | (24) | 80% |
| C | (27) | (68) | (41) | 60% |
| D | (45) | (63) | (18) | 28% |
| Neuropsychiatry | 189 | 329 | 140 | 43% |
| B | 11 | 89 | 78 | 88% |
| C | 22 | 156 | 134 | 86% |
| D | 156 | 84 | -72 | (Surplus) |
| Pediatrics | 113 | 130 | 17 | 13% |
| B | 3 | 44 | 41 | 93% |
| C | 4 | 48 | 44 | 92% |
| D | 106 | 38 | -68 | (Surplus) |
| All Radiology | 133 | 134 | 1 | 1% |
| B | 14 | 38 | 24 | 63% |
| C | 19 | 35 | 16 | 46% |
| D | 100 | 61 | -39 | (Surplus) |
| Cardiology | 3 | 41 | 38 | 93% |
| B | 1 | 22 | 21 | 96% |
| C | 1 | 14 | 13 | 93% |
| D | 1 | 5 | 4 | 80% |
| Other Specialists | 767 | 1427 | 660 | 46% |
| B | 94 | 371 | 277 | 75% |
| C | 190 | 670 | 480 | 72% |
| D | 483 | 386 | -97 | (Surplus) |

1/ These are not true deficits. They would be reduced by grading specialists upwards with accretion of experience and by an excess of volunteers over resignations if such occurred.

2/ The highest grade of quality, B, is roughly equivalent to, but slightly less selective than, Board Certification.

3/ Included alone in Surgery. Not to be added.

In Table V it would appear that the Army's need for specialists is proportionately less than the needs previously shown for all physicians. The inadequacy of specialist supply becomes apparent, however, when we compare availabilities and requirements, grade by grade. The "B" specialists, who are roughly equivalent to certified members of the Specialty Boards but include a few physicians who are not certified, and the "C" grade physicians who are not quite so highly qualified, are both shown in the following table to be in relatively shorter supply than all other physicians. This shortage is not apparent when examining figures combining all specialists, since almost three-fourths of them are "D" grade specialists, a category which contains many of the young and recently appointed residents. It also contains 800 ASTP physicians.

On 1 July 1948, the Army had 1,808 specialists. When it reaches its presently contemplated maximum strength on 1 July 1950 it would need at least 1,207 more. Assuming that gains of specialists kept pace with their losses, the deficit for an Army almost 50 percent larger would be at least 40%. But the deficit for "B" and "C" grade specialists, the more highly qualified, would be 78% and 72% respectively, according to the Army's requirements. If all of the present "B's" remain, and if all of the Army's present "C" grade physicians became qualified as "B's", only about 75% of the "B" grade requirements will be met.

Or, to consider the "D's", if all of the present ones were graded upwards within the next twenty-one months, which would

doubtless require a relaxation of criteria for grading as well as a totally unwarrantable assumption that all residents and ASTP men would remain in the Army, the combined requirements in the "B" and "C" grades would still have a deficit of about 15%.

It is apparent therefore that the Army faces a more important problem in providing quality of care than in furnishing quantity. In the nation as a whole, one doctor out of every six or seven is a specialist, certified by a Board. In the Army the Board members (124) occur at the rate of about one out of 33.

TABLE VI

PHYSICIANS AND SPECIALISTS IN ARMY GENERAL HOSPITALS

| | Availabilities, 1 July 1948 | | | Requirements, 31 December 1948 | | |
|---|---|---|---|---|---|---|
| | Total | In General Hospitals | % G.H. | Total | In General Hospitals | % G.H. |
| All Physicians | 4350 | 831 | 19% | 6307 1/ | 1018 | 16% |
| All Specialists | 1808 | 580 | 32% | 2575 | 859 | 33% |
| B | 160 | - | | 631 | 355 | 56% |
| C | 377 | - | | 1135 | 282 | 25% |
| D | 1271 | - | | 809 | 222 | 27% |
| Surgery | 603 | 208 | 33% | 819 | 274 | 33% |
| B | 37 | - | | 141 | 84 | 67% |
| C | 141 | - | | 356 | 98 | 28% |
| D | 425 | - | | 322 | 92 | 28% |

1/ Includes non-operating physicians, comparable to the total of 4350 for availabilities.

About a sixth of the Army's workload, in terms of medical personnel, is found in the general hospitals. A glance at Table VI, however, shows that these hospitals account for a much higher proportion of the requirements for specialists. Were it not for general hospitals the requirements for all medical officers as of 31 December 1948 would be reduced by 1018, or 16%, while the requirements for all specialists would be lowered by 33%.

The broad use of the term "specialists" serves to obscure the real personnel cost of these hospitals, since they not only require relatively larger numbers of specialists but also the most highly qualified ones. Considerably more than half of all physicians graded "B", the ones who are and can be expected to remain in shortest supply, would be assigned to general hospital staffs. The Army had only 160 "B" men on 1 July 1948, or about one-fourth of those required by 31 December. Even if none of these were needed in general hospitals, there would be a 50% deficit in this group. The same situation obtains with respect to "C" specialists. Although the general hospitals use them in lesser proportion than "B" men, their requirements, if fully met from present strength, would leave only 95 physicians to meet the Army's requirements outside of general hospitals for 853.

Thus it is seen that the most highly qualified men, who are also the ones in shortest supply, tend to be concentrated in general hospitals.

Personnel Requirement: Motivation

To conduct a medical service it is not only necessary to have a personnel in adequate quantity and with proper technical qualifications. It is no less necessary that they should have a relatively high degree of motivation. The Army unfortunately has had, and still has, deficits in all three requirements. Just as consideration of quality in physicians is usually subordinated to concern for their numbers, so do the values of motivated personnel receive attention second to that paid their qualifications.

No methods have yet been devised to measure the productivity of physicians in either volume or quality, nor do measures exist for the effects of motivation. We can only speculate upon the differences between medical services rendered by persons who freely chose permanent careers, by persons who were persuaded to volunteer for active duty, or by ASTP physicians who were involuntarily drawn into service.

It is not pertinent here to examine into the justice of involuntary service by ASTP physicians and dentists. It is important, however, to recognize that their temporary integration with other personnel, who entered the Medical Corps upon an entirely different basis and by virtue of this had attained a status denied to the ASTP graduates, led to what the sociologists would term an in-group/out-group relationship which is unsatisfactory and disturbing. There is evidence from surveys and observations, in the Zone of the Interior and overseas, that this mixture did not go into solution and that there has been a strong tendency for a master-slave relationship to develop.

While it may be equally as unavoidable for the Army to draft physicians in the future as it was in the recent past to induct ASTP graduates and assign them to duty with Regular Army physicians, it is necessary, that we may be fully cognizant of what to expect, to reflect upon the experience following upon this latter action.

ASTP physicians received all or a part of their medical education at government expense. Their feeling of debt to the government was not sufficient to compensate for their intense dissatisfaction upon being called for service, however. Perhaps the simplest index of their dissatisfaction with obligated service is the simple fact that almost every one of them, whether physician or dentist, has left the Army just as soon as his legal commitment terminated. Our Subcommittee survey (See Appendix 50) shows no reason to expect those now on duty to behave otherwise. A half or more of them say they like their work in the Army "as a professional person" and claim their skills are at least fairly well utilized. While this degree of job satisfaction would be considered low in a civilian enterprise, it would not be low enough to account for wholesale resignations. The core of the ASTP man's attitude is undoubtedly revealed in the words of those who said I do not like to be treated as a servant. In civilian life the physician is a respected member of society. In the Army he is a servant, and the lowest form of officer personnel." Moreover, "no one who has spent ten years preparing for a profession wants to throw himself to the mercy of such a haphazard organization as the service has proven itself to be."

While dissatisfaction is most widespread among ASTP men, only 64% of the others plan to stay in service until retirement and 7% of them say they would "get out now if permitted."

Dissatisfaction overseas is equally intense. A consultant to the Surgeon General reported after his recent trip to Europe that "great antagonisms are at large" between "civilian doctors in the Army and Regular Army doctors." Principal elements in this antagonism are (a) lack of full responsibility and failure of understanding and (b) fear and authoritarianism which is shown by both sides. (See Appendix 51).

"The Composite Army View. There is bitter criticism of the ASTP products by the Regular Army doctors and by line officers as well. And there is a good basis for their criticism. They say, "You ASTP officers were spared the life and hazards of the foot soldier. You were educated at Government expense while others were separated from their families, were wounded, were killed. You owe a very great debt to your country, and now you complain when payment on this debt is required, even though your payment is on far easier terms than were required of your colleagues in combat. Your attention is not fixed on doing a good job. It is fixed far too often solely on getting out of the Army at the earliest possible date. You do not utilize the opportunities we gave you. You are too young to realize that a dispensary practice covering soldiers and their dependents is very similar to what you will meet in an office practice. You fail to grow as a result of this experience. You do a poor job, and we will thank God when we can get rid of you.

"The Composite ASTP Officer's View We were illegally threatened by local officials that if we did not join the ASTP we would be thrown out of medical school and drafted into the infantry. After we got in there was no reasonable uniformity of administration of the program from one school to another. Too much was left to the decision of the local commander, a man who too often had no concept of the requirements of the medical student's heavy work schedule. Accordingly, in some schools we spent hours every week at drill, standing retreat, on spit and polish that had nothing to do with our job of learning medicine. Infantrymen don't learn first aid. What is the point of medical officers learning close order drill? Or doing MP duty as some had to in Italy during the War? (One of us here overseas has a CO who suggests closing the dispensary so his medical officer can take secondary training, demolition, firing, etc. In another hospital

medical officers must drill, stand retreat, etc. why?) But back in medical school some of us were needlessly billeted in large groups in warehouses where there were no facilities for study. Under these circumstances the quality of work (grades) in entire schools fell.

"After we had completed work for the degree we went to Fort Sam Houston. We had a pretty good course there and morale was high. A good many of us thought favorably of joining the Regular Army. A team of high ranking officers came down from the Surgeon General's Office for official interviews. They made good promises and 'official' commitments. They made such big statements as to what we would do and where we would do it, some of us began to get suspicious. When we learned later that our orders had already certainly been cut even when these fine words were being given out we knew we could never trust the Army again. Some of us who believed all these promises at Fort Sam Houston found out later what a joke it all was. We didn't expect fine promises. It would have been better for the Surgeon General's official representatives never to have said anything than to have made these promises they must have known wouldn't or couldn't be fulfilled.

"'What is all of this talk about the U.S. never having legalized discrimination against a class? The training of each pilot cost the taxpayers far more than our training as doctors. They are not held and we are. Isn't this legalized class discrimination?'"

In his discussion of the factors of fear and authoritarianism the observer says: "fear and distrust are inseparably linked and are at the bottom of much of the antagonism between the Regular Army doctors and those of the ASTP. In nearly every hospital, dispensary and field aid station I have been in I have heard it said by ASTP medical officers 'You can't trust the Army' -- to be followed by a long list of personal instances. In this mistrust lies a great key to the problem and a clear indication for repair. Specifically, the ASTP officers fear their Commanding Officer and his numerous ways of making life uncomfortable for them."

Moreover, he says, "The Commanding Officers fear the ASTP officers because the former know that because of their long absence from clinical medicine enforced by the war, the ASTP officers know more clinical medicine than they do. Some of the Commanding Officers are not big enough to accept this plain fact; they bluster; they try to cover it up. Too often this takes the form of public humiliation of the ASTP officers. On the other hand these young officers, because of their youth, inexperience and tactlessness, add to the tension."

Even if the low motivation indicated above does not serve to depress the level of medical care given by this personnel, it is certain, so long as it continues, to undermine any voluntary recruitment program which the Army conducts. The civilian doctor was recently conditioned in the negative toward military medicine by the attitudes of those returning from war service. If many thousands of obligated service physicians continue to return to civilian life each year the prevailing attitude toward military medicine will be indefinitely perpetuated.

The following section of this report, containing a statement by the Surgeon General on the Army's medical personnel situation, shows that the problems described above are officially recognized.

Medical Personnel Problem as Stated by Office of the Surgeon General

"1. The outstanding personnel problem in the Medical Department is the shortage of personnel. The reason for this shortage has been made a matter of continuous study for more than two years and it is believed that all the underlying causes are known; some of them can be solved and are being solved within the Medical Department. Others require action outside the Medical Department, either by policy changes or legislation. The reasons for disinterest in the service are enumerated below, with analytical comments on each reason.

"(a) Lack of adequate professional training programs and facilities. Training programs have been established in six general hospitals to the extent possible considering clinical material and instructor personnel. These programs have been under close surveillance of professional civilian consultants who are utilized to the maximum in conducting the programs. As soon as teaching staffs can be made available, two additional hospitals will be brought into the training program. All advice from civilian experts who have reviewed these courses is to the effect that they are equal to those being conducted in civilian hospitals in most instances.

"(b) Lack of respectable housing. This complaint, of course, applies to the Army and Air Force as a whole. Housing, however, is especially inadequate at many of our general hospitals. Doctors feel that in civilian life they would not have to subject their families to living conditions which are comparable to those they must endure while in the service.

"(c) Too frequent moves. The policy of the Army is to strive for retention of all officers for three or four years in their assignments. This has been impossible of accomplishment because more than three-fourths of the officers on duty with the Medical Department have tours of less than two years' duration. (These are ASTP and volunteers). Frequent moves have cost many officers considerable monetary losses and are, without question, exceedingly objectionable. If housing were available, however, the objections to move would not be so serious, but when a move means the separation of families for weeks, or even months, until housing can be found in a new location.objections understandably result.

"(d) Undesirable assignments. (Most frequently mentioned are those in dispensaries and in overseas stations). The Surgeon General has advocated a rotation policy between hospitals and dispensaries for all officers. This is very difficult to accomplish, however, because the majority of our officers are on duty for less than 24 months and when one of them can be trained to accept responsibility in a surgical service or medical service his commander is extremely loath to release him and take an individual with the same time to serve, in the hope that he can also be trained to accept these responsibilities. Localities in the Far East have been extremely difficult to staff, principally because of the long separation of families.

"(e) Impossible working conditions. (Most frequently mentioned are the unreasonable demands of line officers who leave the impression with young officers that they are on a servitude plane.) Doctors are individualists. Their long and intensive training makes them one of the most educated classes of individuals in the world. They like their profession and want it respected. They resent being controlled by authority on matters concerning which they have superior knowledge.

"(f) Lack of medical control of facilities and personnel. The organizational trends of the past few years in the Army toward decentralization through military command channels has been to the dislike of medical personnel. It is the present trend of medical officers in the Army that they like to look to the Surgeon General as one who is able to assist them in their problems.

"(g) Inadequate pay -- not all comparable to that in civilian life. Even with the additional $100 per month authorized by Congress in August 1947, the inequity between pay in civilian life and in the military service has not been corrected. Several pay studies are in process in the Armed Forces but at this writing the recommendations of these studies are not known. It is likely, however, that medical service in the Army will not be attractive to young professional personnel until some basis can be devised to equalize pay.

"(h) Too many non-medical duties. The Surgeon General has been endeavoring to solve this problem for the past few years. The Medical Service Corps was established for this specific purpose. The Inspector General and the Surgeon General conducted a survey during this year in an effort to determine how many non-medical duties were being performed by professional officers. The results of this survey indicate that very few doctors or dentists are performing non-medical duties. It is therefore felt that this complaint may have been eliminated.

"(i) No assurance that assignments will be along line of training. The Medical Department has developed an elaborate career plan for every professional officer in the Department. Every officer is classified in accordance with his training. His assignment orders require his commander to give him assignments in accordance with his classification. This system has been developed, it is now in operation and time alone can prove its permanence.

"2. Our training program, our career management and classification systems, our consultant visiting system, both in the United States and overseas, and our transfer of doctors from administrative to professional duties and their replacement by Medical Service Corps officers if vigorously pursued and allowed to continue over a period of years will positively correct many of the causes of disinterest mentioned above. The principal remaining unsolved problems are pay, housing, moves, assignments, and control. Correction of pay and housing discrepancies will require legislation; and less frequent moves can be accomplished only by lengthening tours of duty. When the Regular Army Medical Corps is

filled to its authorized 3,000 strength and when the other Corps are filled to their authorized strengths, more stabilized policies regarding moves can be pursued. Likewise, assignments, and thus utilization can be improved only by stabilization of the personnel in the Department.

"3. Since soon after the end of World War I until the passage of Public Law 381, 80th Congress, the Medical Department had a promotion system whereby officers were promoted after a certain number of years' service in grade, provided they were professionally qualified, as determined by examination to assume the duties of the higher grade. Public Law 381 changed that system to one of selection, whereby officers are promoted by action of a board of officers. This has been in effect only a short time and there are many doubts in the minds of medical officers as to whether the new system can be made satisfactory. This, of course, depends upon many factors, one of which is the efficiency reporting system now in effect in the Army, and which is of questionable merit.

"4. The characteristics and requirements of medical service in determining the desirable type of organization and operation might be enumerated as follows:

"a. The American public demands for each soldier and air man the best medical care that medical science and efficient medical organization can provide.

"b. The complex nature of medical science demands a well-integrated organization with adequate professional and administrative supervision from the top to insure that every patient receives the benefit of the knowledge, skill, and experience of the leaders of the profession.

"c. Distribution and redistribution of specialists must be accomplished with regard only for the effective use of their special talent and by a central authority which knows both Army-wide requirements and Army-wide assets of this short personnel.

"d. Medical service is such that its nature requires that both its supervision and its evaluation be done by men with professional training.

"Some of these factors conflict with the Army's concept of command responsibility, which states that 'The commander alone is responsible for all that his unit does or fails to do.' It does not seem that this concept is realistic. The line commander does not have the technical knowledge necessary to accept responsibility for medical service in his unit. The Surgeon General is held responsible for the standard of medical service in every unit in the Army by the profession as a whole and also in truth by his superiors. He can meet that responsibility only if he can control his medical means. With professional and technical controls through

medical channels, authority and responsibility would be parallel. This can be accomplished only by modifying the Army concept of command responsibility. Such a concept exists in the United States Navy where four components of command are recognized; military command, coordination control, management control, and technical control. It is the opinion of the Surgeon General that the prominent concept, even of junior officers, of a lack of medical control can be corrected only if the Surgeon General has technical control of all medical activities and Medical Department personnel, as well as management control of all medical installations.

5. "Insofar as recruitment for the various regular corps of the Medical Department is concerned, the following general observations are made:

"a. Medical Corps: -- Early in this year it was evident that the Medical Corps could not be filled by the ordinary integration processes in use by the Army as a whole. The one advantage the Army seemed to possess in interesting young officers in the military service was pay during training. In civilian life interns and residents are poorly paid but we are able to extend to our interns and residents the pay of their grade. It was not possible to establish positions in intern and residency programs in Army installations in sufficient numbers to accommodate enough officers to fill the Regular Army authorization. It was necessary to go to civilian life and at the present time a limited number of interns and residents in civilian life are drawing Regular Army pay of their grades while pursuing their post-medical education. This program, if it can be pursued without interruption, will fill the Regular Army Medical Corps authorization within three years. Holding these officers in the Regular Army, however, depends upon correction of the elements of dissatisfaction which are enumerated and elaborated upon above.

"b. Dental Corps: -- The dental profession has no universally recognized internship or residency system. It has therefore not been possible to devise a system similar to that mentioned for medical officers to fill its authorization. The discrepancies, however, enumerated in this statement all apply to dental personnel also. Filling of the authorized strength of the Regular Army Dental Corps depends upon correction of the reasons for dissatisfaction.

"c. Veterinary Corps: -- The Regular Army Veterinary Corps is filled to its authorized strength. Additional officers for the expanded forces are difficult to procure because of the same reasons for dissatisfaction outlined above.

"d. Army Nurse Corps: -- Procurement for the Regular Army Nurse Corps is proceeding in the following manner -- selections are made from among those who have served six months on a Reserve Active Duty status. The pay of Army nurses does not present the discrepancies which exist in nurses which is reflected in our recruitment program.

"e. Medical Service Corps: -- The Medical Service Corps is now composed of four sections: (1) Pharmacy, Supply and Administrative Section; (2) Allied Sciences Section; (3) Sanitary Engineering Section; and (4) Optometry Section. The Allied Sciences Section consists of bacteriologists, parasitologists, serologists, biochemists, laboratory officer general, nutritionists, entomologists, psychiatric social worker, and clinical psychologists. This group also presents an extremely difficult procurement problem for the reasons above mentioned.

"f. Women's Medical Specialist Corps: -- This Corps is composed of the dietitians' section, physical therapists' section, and occupational therapists' section. This is a new Corps and cannot be filled immediately. However, conditions concerning the Corps probably would indicate that no serious procurement problem exists, although shortages in authorized strengths will be evidenced for several years."

Further Measures Undertaken to Correct Shortages

Two of the most significant actions taken since the war to correct shortages of medidal personnel are the utilization of ASTP physicians and dentists and the inauguration of residency training programs in Army and in civilian hospitals. The first action was undertaken to make up personnel deficits in quantity, the second, to provide the quality needed through specialist services.

12,500 medical and 1,961 dental graduates of the ASTP program have served in the Army. Those in dentistry have completed their service and the last group of physicians is now in the Medical Corps, where it constitutes about three-fifths of total strength.

The Army has 381 medical residents in its general hospitals, 47 of whom will have completed formal training for their Specialty Board examinations by 31 December 1948. The first residents and interns in the civilian training program were commissioned on 1 July 1948. With a program calling for 300 in each category there are now 259 residents and 181 interns.

Consulting physicians have been appointed not only for teaching in the residency programs but also to act as visiting consultants to medical installations overseas. Each month a team consisting of a surgeon, internist and a psychiatrist visits the overseas services. At intervals of six and twelve months such a team is augmented by other specialists.

Attempts have been made to carry a part of the Army patient load with regularly employed civilian personnel but due to the location of much of the work, the restrictions on salaries offered and competition from other government agencies these efforts have been relatively unsuccessful. One deterrent to the use of civilians is the fear that

if they are used to replace Regular Army personnel in the better installations the latter will resign. Few civilians will accept employment readily in the undesirable locations.

A particularly acute shortage of dentists in 1946 was solved temporarily by a three-cornered arrangement with the Navy and the Veterans Administration involving ASTP and V-12 personnel. By next year the deficit in dental personnel will again be serious.

An attempt has been made to achieve greater utilization of medical personnel by transfer of administrative work to members of the Medical Service Corps and other non-technical personnel. This success of this effort has not been sufficient to cause a reduction in the Army's stated requirements for physicians, dentists and nurses.

It was expected that the system of "career planning" would prove to be an additional recruitment incentive. Under this plan an effort is made to assure the physicians of continuity in the field of his special interest.

Further Measures Proposed

In an attempt to arrive at its standard for medical service in both quantity and quality, the Army proposes to continue and intensify the measures it has already undertaken. Despite poor success to date in this program, further emphasis will be placed upon procurement of civilian physicians and dentists.

A plan is contemplated to train members of the Wac as practical nurses to compensate for the shortage of graduate nurses. This has already been started on an experimental basis in one hospital.

It is planned for the general hospitals to absorb eleven of the existing station hospitals and in a further effort to concentrate physicians and move patients to them it is planned moreover that certain dispensaries should be eliminated and combined.

Joint staffing by the Army and Navy personnel is also sought.

A plan to secure medical personnel from medical schools is contemplated and will be proposed at the forthcoming annual meeting of the Association of American Medical Colleges. The Army hopes to get each school to agree to, and arrange for, two or three members of its clinical staff to accept reserve commissions and report for six to twelve months active duty. The most highly qualified would be used in the Army residency program, while others would be used in station hospitals. It is hoped 200 specialists may be acquired by this method.

Expansion in residency training is proposed.

The measures undertaken and proposed are not expected to meet the stated requirements for personnel. When the new Congress is convened the Armed Forces will again request legislation for a draft of physicians and dentists. Similar legislation was defeated in the retiring Congress through the opposition of organized medicine. Spokesmen for the American Medical Association promised to recruit personnel for military requirements if the draft legislation were withdrawn or defeated but, as of 1 September 1948, the Army reported that no physician had volunteered for duty as a result of this promise.

Under the bill which was defeated physicians and dentists between the ages of 26 to 44 inclusive who had not served on active duty would have been subject to draft.

Evaluation of Measures Proposed

Personnel by draft. The provisions for drafting physicians and dentists, which were deleted from the Selective Service Bill before enactment, specified that the first persons to be called would be those who participated as medical or dental students in the Army specialized training program and have had no active duty as commissioned officers. In the draft to be requested of the next Congress by the Secretary of Defense priorities affecting medical personnel have not been fully determined. ASTP graduates are still considered to "owe" most service to the government, however, and we must assume they will be drafted before others.

In view of the Army's inability to secure physicians as volunteers, it seems evident that a draft is necessary if the present medical functions are continued and if the strength increases as planned. The Army estimates there are 3,500 ASTP physicians who have had no active duty. This number would meet the Army's numerical needs for a considerable time. (See Balance Sheet, Supplement A).

How to meet the Army's needs for medical needs for medical quality is a much more difficult problem. During the next year or two the Army will lose specialists as well as general duty physicians. In 1950 the Army would have for a strength of almost one and a half million men fewer specialists than at present, a number which is already far below stated requirements for the current strength of only a million men. Assuming a draft law would apply to physicians in the same age group as that proposed in the Selective Service Act, 26 to 44 inclusive, and

assuming further that it would grant executive power to select personnel for whom there is special need, the requirements for specialists theoretically might be met. If those who have had military service are exempted, however, which also is a justifiable assumption, the draftable reservoirs in many special fields will be so small that persons must be selected almost by name.

Complete data are not available on the numbers of non-veterans specialists in civilian life under age 45 but it can be calculated that they constitute less than 30 percent of all those who limit their practice to a specialty. This estimate is based on a study made by the subcommittee of the status of physicians certified by the American Board of Surgery, more than 70 percent of whom have been, or now are, on active duty with the Armed Forces or with the Public Health Service. With no reason to believe the contrary, we may assume that military service has been rendered in the same proportions by certified and non-certified surgeons, and by all surgeons and other specialists.

According to A.M.A. reports there are now 6,456 physicians in the country who limit their practice to general surgery. Of these 3,387 are certified, and among the certified only 1,583 are now under age 45. From this group a few may be eliminated since they are female or known to have physical disabilities. 1,130 of the remaining have had military service. Thus, only 29 percent of all certified general surgeons under age 45, or a total of 453, would be procurable for military service.

This high rate of exemption is not a temporary situation. A study of the records of 562 surgeons awaiting Part 2 of the Board's examination reveals 76 percent are service exempt for one reason or another. And in the group now taking training which leads toward certification in general surgery, analysis of our correspondence with 51 schools and hospitals shows, 81 percent have served in the Armed Forces or in the Public Health Service.

While it would be difficult to estimate the number of all general surgeons in the reservoir available to the Army and Navy, it is clear that it contains only a minority of those with unquestionable qualifications. (See Appendix 16). The Army now has 12 and the Navy 10 board members. As of 30 June 1949 additional Armed Force requirements for top grade physicians, who usually but not always are certified, are estimated at 50. This would be about 11 percent of all those in the total category throughout the country who are not service exempt. Assuming that any draft of physicians would not exceed five percent, it is concluded that it would not without special provisions procure surgeons in the proportions needed.

From the above it may be concluded that the Army cannot continue its present medical care functions, under its stated requirements for personnel, without a draft to supply the quantity needed, and furthermore that, even with a draft, unusual measures would have to be taken to procure the specialists needed for a service of standard quality. Legislation authorizing such unusual

measures, since it will be recognized as defining anew the boundaries of the government's power to enlist the services of its citizens, will undoubtedly meet with strong opposition.

Expansion of training programs. Army residency training of physicians, both in its own hospitals and in civilian hospitals, appears to have limited usefulness for recruitment of specialists. Only a fraction of the newly increased requirements could be met by this method within the next several years, even granting that substantial numbers of the specialist were integrated into the regular establishment. Until now, however, Army experience has been too brief to show how many residents would stay in service permanently. There is much reason to believe that many if not most of them will leave the Army as soon as their period of obligated service is over. Neither is it known yet whether during their obligated service these physicians will operate willingly and effectively.. If they react as the ASTP physicians now on duty, or as the physician in civilian life who were assigned to practice in the south in return for subsidy of their medical education by the Commonwealth Fund, their value to the Army, and their permanence in it, would have to be discounted. We have no evidence to show that personnel rendering obligated service are any more highly motivated or any less disaffected than personnel drafted under explicit legislation.

Further questions are raised by the Army's residency program in terms of money and personnel costs. While it is impossible to compute either of these with accuracy, there is still some doubt that the number

of specialists to be recruited through Army hospital residencies justifies the maintenance of teaching facilities and the administrative burden on the Surgeon General's office. Although these residents help carry the workload, there is question as to whether such a workload, with its heavy patient components of dependents and veterans, can be identified with the primary mission of the Army Medical Corps. The civilian residency program would appear to impose less of an administrative burden on the Army, with true and total allocation of costs, might prove to be less expensive. The question of its long-run effectiveness, however, and its implications for obligated service, cast much doubt upon the program's promise as a lasting solution.

Other implications of these programs are discussed in Appendix 15.

Use of Part-time Civilians. Similarly the employment of part-time personnel offers relatively little aid to the solution of the Army's manpower problem. Visiting consultants overseass are said to stimulate and assist personnel permanently assigned there but are of little help in carrying the workload. Consultants in the general hospitals in this country likewise carry little of the patient load utilized mainly for teaching in the residency programs. The Army reports difficulty in getting enough consultants to be of real value, partly because they are not attracted by the money offered and partly because in the less urban areas they are not to be found in significant numbers. In urban centers, physicians are frequently too busy in Veterans Administration hospitals to be interested in further consultation,

Attempts to contract for full-time and periodic part-time services of physicians, as distinguished from consultant services, are likewise reported to be unsuccessful. Rates of compensation permitted by Civil Service regulations are said to be insufficient to arouse interest in any physicians capable of success in private practice. Civilian physicians are now used for induction examinations but the quality of their services is so low that in certain areas re-examination has led to immediate discharges of as many as ten percent of the groups involved.

Personnel Loaned from Medical Schools. The plan to commission medical school staff members in the reserve and call them to active duty for six or twelve months is a questionable means of securing specialist personnel. The schools, as the Army and all other employers of salaried medical personnel, are suffering from the competition of private practice. In terms of the nation's health, and at the time when the production of physicians lags behind demand, it seems inadvisable for the schools to provide their scarce personnel to the Army.

Career Planning[1/] Army officials are somewhat doubtful that the recruitment power of career planning will be as successful as expected. With medical officers subject to the same complex personnel policies and regulations that govern line officers, and with the exigencies that will characterize an expanding Army serviced in part by obligated or drafted physicians on active duty of short duration, continuity in the same type of duty will become difficult. Those who do manage to remain and become proficient in a specialty, according to

1/ Army personnel statement, Par. 1 i.

present experience, will frequently transfer thereupon to civilian life where they can better capitalize on their skills. Although intelligent and soundly conceived, this plan, to be successful, would depend upon many conditions which are not likely to exist in the Medical Corps of the future.

Shift of Administrative Workload to Non-Professional Personnel. It is not easy to estimate the numbers of physicians who might be conserved by relieving them of administrative duties. A survey by the Inspector General and Surgeon General indicated that very few doctors or dentists were performing non-medical duties. On the assumption that avoidance of all non-medical duties is impossible, it is difficult to know when they are "few" or "many." In a sample questionnaire survey conducted by the subcommittee (see Appendix 50) 46 percent of the Army physicians indicated that an average of 38 percent of their time could be saved by relieving them of non-military duty and by delegating work to ancillary technical and administrative personnel. This would represent about a sixth (17%) of all physician duty-time. Among all physicians in the survey, 18% saw need to delegate work to ancillary technicians, 10% to clerical personnel, 10% to administrative personnel (which probably indicates much the same type of work) and 17% to other military personnel. Numerous complaints in this survey about non-professional work would indicate that the Surgeon-General may possibly be optimistic in his feeling that this "may have been eliminated" as a deterrent

to recruitment. While the Surgeon General mentions "transfer of doctors from administrative to professional duties and their replacement by Medical Services Corps officers" as one of the measures which "if vigorously pursued and allowed to continue over a period of years will positively correct many of the causes of disinterest" in recruitment, a study of the requirements of mendical personnel for the current time and for 1950 shows no provision for such replacement to accelerate as the Army expands. According to these figures, the Army's requirements for physicians will increase faster than those for Medical Service Corps officers.

Despite increased efforts for the past few years the problem of shifting the physician's workload to administrative personnel has stubbornly resisted solution. One part of the problem, as reported by the Army, is the difficulty, similar to that in the Medical Corps, of recruiting personnel.

## PART III. AIR FORCE MANPOWER

Workload When the Air Force became an arm independent of the Army after the Unification Act of 1946, an arrangement was made under which its medical service would continue to operate in large part through the Medical Department of the Army. The Army and Air Force medical services are therefore not comparable in many respects. The Army has the responsibility for certain major overhead functions, for all general hospitals and their residency training programs, and for the bulk of all hospital and dispensary work overseas. The Air Force limits its activities largely to care of troops, the station hospital function, and certain medical functions peculiar to the Air Force.

An indication of the size of the Air Force medical workload, which however has already been reported as a part of the Army workload, is as follows: On 30 June 1948 there were 2,583 military and non-military patients in 54 Air Force station hospitals with a total of 5,650 operating beds. During the year then ending there were 1,207,000 treatments to military out-patients and 862,000 treatments to dependents and other non-military out-patients in the station hospitals and dispensaries.

Personnel Requirements: Quantity

Personnel in the Air Force is recruited and assigned by the Surgeon General of the Army. On 5 September 1948 the physician personnel situation in both arms was as follows:

TABLE 7

Availabilities and Requirements of Physicians
Army and Air Force

| | Army & Air Force | Army | Air Force |
|---|---|---|---|
| Over-all Strength | 1,013,141 | 611,579 | 401,562 |
| Medical Officers | | | |
| Available | 4,350 | 3,450 | 900 |
| Ratio per M | 4.29 | 5.64 | 2.24 |
| Net Requirement 1/ | 5,908 | 4,532 | 1,376 |
| Ratio per M | 5.83 | 7.41 | 3.43 |
| Deficit | 1,558 | 1,081 | 476 |
| % Deficit | 26.4 | 23.9 | 34.6 |
| Ratio per M (1950) | 5.53 | 7.02 | 2.87 |

It can be seen from these figures that the present division of workload results in much higher requirements for physicians in the Army. With duties more in line with its primary mission, being without responsibilities for general hospitalization, residency training and other programs, the Air Force requires fewer than half as many physicians as the Army. It can also be seen that the present deficit in physician personnel is greater in the Air Force, availabilities falling short of net requirements by about 35 percent as compared with a deficit of 24 percent in the Army.

According to present tentative requirements the ratios of physicians to total strength will drop slightly as strength increases during the next 21 months. The drop in the Air Force will be somewhat greater than that in the Army, 16 percent as compared with five percent.

1/ Figures as of 30 September 1948, with little change in strength occurring during period subsequent to 5 Sept. 1948. Gross requirements, showing additional numbers needed for students and for fuller staffing upon alert, are considerably greater.

Personnel Requirements: Quality

The present definition of Air Force medical functions results in considerably lower requirements in terms of quality as well as in quantity. Of all the physicians it requires as of 31 December 1948 35 percent would be specialists, as compared with specialists requirements of 53 percent in the Army. Not only does the Army require proportionately more specialists but requires more of them with the top qualifications which are roughly comparable to Board certification. Of the 631 "B" grade specialists required by both arms, 604 would go to the Army.

TABLE 8

Specialists Requirements, Army and Air Force as of 31 December 1948

| Physicians | Both Arms | Army | Air Force | Army | Air Force |
|---|---|---|---|---|---|
| Total[1] | 5,302 | 3,996 | 1,306 | 100% | 100% |
| Staff | 240 | 137 | 103 | 3.4 | 7.9 |
| Command | 318 | 238 | 80 | 6.0 | 6.1 |
| General Duty | 2,169 | 1,505 | 613 | 37.7 | 46.9 |
| Total Specialists | 2,575 | 2,116 | 459 | 53.0 | 35.1 |
| Total Specialists "B" Grade | 631 | 604 | 27 | 15.1 | 2.1 |
| Total Surgeons | 819 | 635 | 184 | 15.9 | 14.1 |
| Total Surgeons "B" Grade | 141 | 136 | 5 | 3.4 | .4 |

1/ Does not include physicians for non-operating purposes.

Personnel Requirements: Motivation

In general the problems of motivation among Air Force medical personnel can be likened in kind to those in the Army. Those which revolve around the use of ASTP men are apparently the same in both arms and therefore call for no further discussion. In degree, however, motivation seems to differ.

For some reason or other, the level of job satisfaction among Air Force physicians and dentists is lower than that in the Army according to the Subcommittee survey. (See Appendix 50). This does not apply to nurses, whose job attitudes are about the same in both arms. Comparisons of responses to questions concerning job and "morale" attitudes are highlighted below:

TABLE 9

| Response | Physicians | | Dentists | |
|---|---|---|---|---|
| | Air Force | Army | Air Force | Army |
| a. Percent of sample saying their professional skills are being used "very well" . . . . . | 36 | 43 | 41 | 59 |
| b. Percent saying they are "very well" satisfied with present assignments . . . . . | 40 | 46 | 35 | 51 |
| c. Percent rated by analyst as having low job satisfaction | | | | |
| Among ASTP's . . . . . | 56 | 47 | 55 | 54 |
| Among Others . . . . . | 13 | 3 | 13 | 3 |
| d. Percent of separatees who, under the necessity to return to government service, would choose to return to same agency . . . . . | 23 | 27 | 19 | 13 |

With one exception, all indications of the above table are that Air Force personnel are less well satisfied than that of the Army. The exception is in the case of dentists who have been separated (line d).

When asked which agency they would choose to work in if it were necessary for them to return to government service, dentists separated from the Army would have slightly more reluctance to return to the Army than the Air Force separatees would have for return to their agency.

This showing of relatively lower satisfaction is not a function of the numbers of ASTP men involved. When shown separately, it can be seen (line c) that the differences between Air Force and Army regulars and volunteers are greater than those between the ASTP's. (See Appendix 50 for full report.)

Two reasons are suggested in explanation of these data. The Air Surgeon believes that officer morale suffers as a result of the arrangement with the Army Medical Department, which inhibits the development of the Air Force medical service as an efficient team. The other interpretation is that the Air Force service, being limited largely to care of troops and station hospital functions, provides few opportunities for that broad practice of modern medicine necessary to full professional development.

Measures Undertaken

The Air Force has undertaken various minor measures to compensate for the shortage of personnel which it shares with the Army. For the medical staffing of radar stations and other small installations it has begun to train enlisted men in first aid and preliminary diagnosis so that, somewhat like the Russian feldschers, they may answer some of the need for fully trained physicians. Training courses have also been conducted for flight nurses, X-ray technicians and other ancillary workers.

The measure upon which greatest emphasis has been placeed however has been the systematization of the field of aviation medicine. The Air Surgeon believes this field is justifiably distinguished from general medicine and from other medical specialties and that it is only through the development of proper prestige for aviation medicine that the Air Force can attract and retain medical personnel sufficient in quantity and quality.

Measures Proposed

In order to further the emphasis on aviation medicine and to gear medical service more closely to the mission of the Air Force, the Air Surgeon proposes a service separate from that of the Army. In a discussion of what he considers to be serious disadvantages in the present arrangement with the Army Medical Department, the Air Surgeon made the following statement:

> "The successful discharge of the expanded mission of the Air Force requires the complete integration of the personnel, equipment, installations and machinery necessary for the exploitation of air power into an efficient and closely knit team. Such an arrangement obviously entails the right to 'hire or fire' as well as to reward and punish [the members] of the team. This situation does not obtain under the present organization where the Air Force detailed medical appendage of the Army Medical Department continues to be subject to Army administration of career control, appointment, promotion and separation policies. .....an operational veto remains in the hands of the Army whose failure or inability to provide the medical attendance required by the Air Force might impair the mission of the latter Arm.....Furthermore, it is difficult to minimize the effects of the present organization upon the morale of [Air Force] medical officers.....(See Appendix 35/6)"

It is the judgment of the Air Surgeon that greater independence of his medical service will not only protect the mission of the Air Force but will enable him to recruit physicians who are not attracted by the present arrangement:

> "Now we are faced with a shortage of doctors, a shortage which becomes increasingly significant with the separation of each increment of ASTP medical officers. The procurement program of the Army Medical Department has been unable to recruit the regular strength of the Medical Corps to meet these attritional losses..... Strangely enough this admitted shortage of doctors has been employed by some as an argument against the creation of a medical service within the Air Force. It is difficult to reconcile this view. Actually, the shortage is in itself the strongest indication of something amiss. I could think of no better justification for a reorganization of the system of medical attendance than the fact that the present arrangement makes so little appeal to the civilian physician."

On the basis of two questionnaire surveys conducted by his office, the Air Surgeon concludes that "an untapped reservoir of doctors is available to the Air Force" if he is given organic control over personnel so that they may be recruited and managed directly.

Evaluation of Measures Proposed

The question as to whether the medical service of the Air Force should be separated from that of the Army to the extent indicated in its proposal (see Appendix 35) is of concern to this subcommittee only insofar as it bears upon the manpower problem of all the agencies. Here two questions are involved: (a) Would such reorganization increase the requirements for medical personnel? and (b) Would the Air Force and Army be able to recruit a greater total of volunteer personnel under the proposed separation than under the system which now exists?

(a) Under the Air Surgeon's plan, as stated, major responsibility would be left with the Army for general hospitalization. The Air Force would have only one such insitution, a 350-bed aviation medical center, the emphasis of which would be upon research and training in medical problems peculiar to aviation rather than upon care of patients with ordinary types of disease and injury. It is said that the staffing of this institution, together with other innovations under the new plan, would increase requirements for personnel by fewer than twenty physicians. This effect upon requirements, if controlled to such degree, would not be significant. If the new center, however, with a training program for residents, led to need for a variety of clinical material which in turn led to need for further hospital facilities and personnel, its initiation would be questionable.

(b) The Air Surgeon interprets a survey recently conducted among medical students, interns, residents and practicing physicians in civilian life to indicate that the Air Force has for certain persons an appeal that the Army does not have. Careful analysis of this survey report (see Appendix 36) indicates that such a differential appeal does exist but that

it is too tenuous to support a prediction that numerous physicians would actually volunteer. This appeal is signified by expression of "interest" in the Air Force medical service, which would be difficult to translate into actual recruitment.

In large part the interest of the interviewees is expressed after consideration of a number of assumptions as to what the Air Force would have to offer. These assumptions, as stated by the Office of the Air Surgeon, include the following items:

> That hospital facilities equivalent to those of the Army would be provided;
>
> That medical officers in the Air Force will have opportunities for diversified medical practice in the treatment of service families, including women and children;
>
> That approximately three out of the first ten years of service would be assured in specialized training in military or civilian hospitals or institutions, with personal preferences of the individual medical officer given every consideration;
>
> Probable opportunity to take flight surgeon training with extra pay during the course and after its completion;
>
> Probable opportunities for research in aviation medicine;
>
> Etc.

Presumably any responses made on the basis of these assumptions must be discounted since the reorganization plan of the Air Surgeon, as he explained it to the Medical Services Committee on 24 September 1948, does not now embrace a system of general hospitals. In a subsequent letter to the committee (see Appendix 37) the Air Surgeon said he saw no possibility under present conditions of manning general hospitals. The extent to which knowledge of this fact would have altered responses to the questionnaire is not known.

As would be expected, the assumption with greatest appeal was that

concerning residency training which, in the absence of general hospitals, presumably would be conducted in civilian hospitals. The proportions of respondents who indicated interest in this provision for training ranged from 73 percent to 68 percent among medical students, interns, residents and practicing physicians. From a third to a half of them said they were attracted to the Air Force because of the opportunity for diversified medical practice in the treatment of service families, including women and children. Only about a fifth expressed interest in aviation medicine research and only a tenth in the opportunity to travel.

Despite this evidence that the Air Force has no overwhelmingly peculiar appeal to physicians and medical students, the main conclusions of the survey are sufficiently conservative that they must be assumed as valid if the conditions were fulfilled:

> "1. The Air Force plan (represented by the assumptions) would attract a number of men not interested in the Army program.
>
> "2. Some men, otherwise interested in Army medical service, would be drawn away to the Air Force if the plan were put into effect.
>
> "3. There still would remain a number of men, larger than the number diverted, interested only in Army service."

It is the feeling of your subcommittee that there should be a more highly unified procurement program in the Armed Forces than exists at present, and that there should not be three programs conducted independently. There is reason to believe, however, that each arm has to greater or lesser degree a service-identified appeal which, in times of serious personnel shortage, should be exploited. While it is unlikely that the Air Force by more direct recruitment can procure large numbers of additional physicians or dentists, their procurement in even relatively small numbers would seem to justify that degree of autonomy which would be accorded the Army and the Navy under a general recruitment program supervised or coordinated in the Office of the Secretary of Defense.

## PART IV. NAVY MANPOWER

Introductory Comment

Without attempting to minimize differences it can be said in general that the medical manpower problem of the Navy is the same as that in the Army. While certain aspects of the problem differ in degree, and while there are certain differences in personnel management between the two services, there is no difference which is important in character. The Navy:

Has roughly the same pattern of hospitalization;

Has patient loads with similar components of dependents and supernumeraries;

Has both continental and overseas installations;

Has approximately the same requirements for medical personnel in terms of total strength;

Has same grades and pay scales and similar management policies for personnel;

Also emphasizes residency training programs in military and civilian institutions in an effort to procure personnel;

Has Regular Navy components which show more rapid turnover than previously and which attract personnel far too slowly to meet demands;

Has now, or will have within the next year, substantial deficits in all categories of medical personnel; and

Has utilized all procurement devices which it considers suitable and feels there is no solution except to have a draft of doctors and dentists.

Since the similar character of the Navy's medical manpower problem introduces no implications for administrative, organizational nor legislative decisions which differ in kind from those raised by the problem in the other Armed Forces, it will be treated here only to the degree necessary to outline the major variations and to substantiate the essential similarity.

Workload The primary workload of the Navy consists of comprehensive medical care to 490,207 enlisted men and officers, the combined strength of the Navy and Marine Corps (30 June 1948).

The workload carried by 2,711 physicians on this date is indicated by totals of 39,000 beds and 16,500 patients in the thirty hospitals and 147 dispensaries in the United States and overseas. During the fiscal year 1948, there were about 200,000 admissions to hospitals and hospital ships. Overseas hospital admissions totaled about 20,300.

Included in the above is the care of dependents, veterans and other "supernumeraries", which is estimated by the Navy to increase its primary workload by 25 percent. (See Appendix 2/31). Service to persons other than active duty Navy and Marine Corps personnel accounts for 40 percent of Naval Hospital patients.

In a statement before the Medical Services Committee, the Acting Surgeon General said that if the broader missions of the Medical Department are considered the ratio of six and one-half medical officers per 1000 active duty strength is misleading. (See Appendix 2/2). "Originally the mission was the care of the sick and injured of the active Navy in peace and in war. This mission has gradually been enlarged by laws, regulations, directives and new requirements to keep our Medical Department modern and ready for any contingency." ".....dependents number approximately three-fourths of a million people....." "The work accomplished [with dependents] may be summarized briefly on an annual basis as 55,000 hospital admissions, 40,000 home visits, 1,250,000 office visits, 21,000 babies delivered, and a daily average in-patient census of 1000 in our hospitals and 100 in our dispensaries." "Medical care of civilian

employees entailed 678,000 treatments during the past year." "..... ...we plan on having 4000 Veterans' Administration patients in our naval hospitals.....which affords immeasurable advantages to our staff in terms of a greater variety of professional activity and training for our doctors, nurses and corpsmen....."

Personnel Requirements: Quantity

The Navy is almost exactly in the same position as the Army with respect to its numerical requirements for, and deficits in, physical personnel. As of 1 July 1949, the Army expects to need an additional 3,068 physicians, representing an expected deficit of 49 percent. The Navy's expected deficit of 1,727 would amount to 45 percent. Although the Navy was on 1 July 1948 up to strength in its Dental Corps, its predicted deficit for the corresponding date of next year is 28 percent. Greater success is expected in recruitment of nurses. It is predicted that this Corps will be built up from 67 percent to 75 percent by next July 1.

The personnel problem in the Navy is developing rapidly through the imminent departure of V-12 men, corresponding to expiration of the duty of ASTP men in the Army. The main outline of the problem, with respect to numerical supply, is shown on the following page in Table 10.

TABLE 10

Medical Personnel In U. S. Navy
Availabilities and Requirements

| | 1 July 1948 | | | 1 July 1949 | | |
|---|---|---|---|---|---|---|
| Total Strength | | | | | | |
| Actual | 490,207 | | | | | |
| Planned | | | | 592,290 | | |
| | Actual | Required | Deficit | Estimated | Required | Deficit |
| Physicians | 2711 1/ | 3186 | 475 | 2123 | 3850 | 1727 |
| %Deficit | | | 15% | | | 45% |
| Dentists | 956 | 979 | 23 | 850 | 1185 | 335 |
| % Deficit | | | 2% | | | 28% |
| Nurses | 1956 | 2914 | 958 | 2665 | 3554 | 889 |
| % Deficit | | | 33% | | | 25% |

Participants in V-12 medical program who have not served:

| | |
|---|---|
| 1947 graduates (completed internships 1948) | 1985 |
| 1948 graduates (will complete interships 1949) | 1571 |
| Theoretically available 1 July 1949 | 3556 |
| 1949 graduates (will complete internships 1950) | 1478 |
| Theoretical accumulated availability 1950 | 5034 |

1/ The last class of V-12's, with approximately 850 medical officers, will be demobilized by 1 July 1949.

Personnel Requirements: Quality

The Navy seems to straddle the question as to the emphasis which should be placed upon medical specialist qualifications. On the one hand it preserves the tradition that the Navy's medical needs are so peculiar that each physician must be a general practitioner whether or not he is qualified as a specialist. It was once remarked with pride that the personnel of one ship was served by a fully qualified cardiologist, one of the specialists of greatest numerical rarity. On the other hand the Navy has instituted residency training programs similar in size and scope to those of the Army and places just as much emphasis upon them. Moreover, despite its smaller size, the Navy has more members of specialty boards than has the Army, with 157 as compared with 124.

Due to the fact that almost a third of the Navy's medical personnel are graduates of the V-12 program, who will be demobilized within the next year the Navy finds itself in a situation with regard to specialists requirements very similar to that of the Army. Table 11, prepared by the Navy and shown on the following page, reveals recent specialist deficits of almost 50 percent. Deficits in the subspecialties are very uneven, in some cases exceeding 90 percent.

TABLE 11

PHYSICIAN SPECIALIST REQUIREMENTS
Medical Department of the Navy

| SPECIALTY | ON BOARD 31 August 1948 GRADE 1 | 2 | 3 | Total | Required 31 Aug. 48 | Required 1 July 49 | Required 1 July 50 |
|---|---|---|---|---|---|---|---|
| *Internal Medicine | 4 | 55 | 43 | 102 | 160 | 184 | 219 |
| Allergy | | | 6 | 6 | 11 | 14 | 17 |
| Cardiology | | | 1 | 1 | 10 | 14 | 17 |
| Gastroenterology | | | 1 | 1 | 10 | 14 | 17 |
| Pediatrics | | 10 | 6 | 16 | 45 | 62 | 68 |
| Dermatology and Syphilology | 1 | 2 | 6 | 9 | 38 | 42 | 46 |
| Neuropsychiatry | 3 | 24 | 21 | 48 | 105 | 129 | 148 |
| **Public Health and Preventive Medicine | 3 | 6 | 19 | 28 | 28 | 31 | 35 |
| Physical Medicine | | | 1 | 1 | 12 | 14 | 16 |
| ***General Surgery | 18 | 52 | 70 | 140 | 240 | 262 | 283 |
| Anesthesiology | | 1 | 6 | 7 | 45 | 50 | 58 |
| Obstetrics and Gynecology | 3 | 20 | 26 | 49 | 80 | 88 | 97 |
| Thoracic Surgery | | | 2 | 2 | 12 | 14 | 17 |
| Neurological Surgery | | 1 | | 1 | 12 | 14 | 17 |
| Orthopedic Surgery | 2 | 6 | 15 | 23 | 50 | 55 | 61 |
| Plastic and Reconstruction Surgery | | 1 | | 1 | 5 | 7 | 10 |
| Oncology | | | 1 | 1 | 5 | 7 | 8 |
| Ophthalmology and Otolaryngology | | 10 | 18 | 28 | 28 | 30 | 35 |
| Ophthalmology | | | 7 | 7 | 30 | 35 | 40 |
| Otolaryngology | 2 | 9 | 9 | 20 | 30 | 35 | 40 |
| Radiology | 1 | 19 | 18 | 38 | 60 | 69 | 83 |
| Pathology | 2 | 10 | 11 | 23 | 55 | 65 | 68 |
| Urology | 2 | 24 | 15 | 41 | 50 | 55 | 60 |
| Aviation Medicine | 46 | 56 | 86 | 188 | 363 | 458 | 518 |
| Research | | 4 | 3 | 7 | 45 | 50 | 70 |
| #Other Specialties | 38 | | | 38 | 41 | 53 | 57 |
| TOTALS | 125 | 310 | 391 | 826 | 1570 | 1841 | 2105 |

EXPLANATION:

*Internal Medicine - The majority of the subspecialties are included under this heading. The small number of cardiologists, gastroenterologists, and allergists should be clinicians with outstanding teaching ability in order that an excellent teaching program may be maintained in our teaching hospitals with the minimum number of civilian visiting staff (consultants).

**Public Health and Preventive Medicine - A considerable number of specialists utilized in this specialty are Medical Service Corps officers and not M.D.s.

***General Surgery - The majority of the subspecialties are included under this heading; e.g., proctology, general surgeons with considerable training in urologic surgery, orthopedic surgery training, etc.

#Includes other specialties peculiar to naval medicine (i.e., submarine medi-

Personnel Requirements: Motivation

In general it can be said that physicians and dentists in the Navy are slightly better satisfied than those in the Army. (See Appendix 50.) Nurses are somewhat better satisfied than physicians and dentists but there is no great difference between attitudes of nurses in the Army and those in the Navy. It is to be expected that nurses would be more satisfied than other categories since they are all volunteers. There is every reason to believe that problems arising out of the obligated service of V-12 men are the same as those found with ASTP men.

Our survey reveals that persons whose type of duty or whose duty station is changed frequently are less likely to be satisfied than those who remain longer in the same duty and at the same place. It is difficult to know how to interpret this finding, however, since it probably signifies two different things. It is safe to assume changes often create dissatisfaction. Frequent moves often involve housing problems and result in loss of savings. They interfere with making friends and keeping them. And they make it difficult to achieve status and security as a member of a team. On the other hand it is reasonable to believe that job dissatisfaction is cause as well as effect of duty and station changes. Persons not satisfied with their assignments or living conditions might do poor work or act disagreeably, either of which could be expected at times to lead to transfer. Our findings show that Navy physicians have less change of duty and station than those in the Army. V-12's, however, as the ASTP's in the Army,

are changed more often than other physicians. In both agencies dentists are changed less than physicians. Nurses have still fewer station changes than dentists, but they say that their duty is changed quite often. (See Table 12 for greater detail.)

TABLE 12

Comparisons of Job Attitudes Between Medical Personnel in Army and Navy

| | Physicians | | Dentists | | Nurses | |
|---|---|---|---|---|---|---|
| | Army | Navy | Army | Navy | Army | Navy |
| Percent of sample saying their professional skills are being used "very well"..... | 43 | 47 | 59 | 46 | 51 | 55 |
| Percent saying they are "very well" satisfied with present assignments..... | 46 | 55 | 51 | 56 | 53 | 52 |
| Percent saying that in general they liked their work "as a professional person very well".. | 42 | 46 | 55 | 56 | 83 | 63 |
| Percent saying their type of duty had been changed substantially at least twice in previous twelve months.. | 22 | 14 | 8 | 14 | 22 | 31 |
| (ASTP's and V-12's only)..... | (28) | (24) | - | - | | |
| Percent saying they had changed station at least twice in previous twelve months..... | 21 | 17 | 8 | 14 | 11 | 8 |
| (ASTP's and V-12's only)..... | (29) | (20) | - | - | | |
| Percent of separatees who, 1/ if required to return to government service, would choose to return to same agency..... | 27 | 35 | 13 | 49 | 61 | 61 |

1/ The survey included samples of recently separated physicians, dentists, and nurses as well as those on duty.

Attention is called to the last line in Table 12, which seems to be a good index of the relatively favorable attitude of physicians and dentists toward the Navy. Recent separatees were asked which of all five government medical agencies they would prefer to work in if it were necessary for them to return to government service. Navy separatees showed more inclination to return to the Navy than Army separatees showed for their agency. This was not true for nurses, but was true in the extreme for dentists even though the Navy dentists were not so sure as Army dentists that their professional skills were being utilized properly.

These data, plus free comments written on the questionnaires by respondents, tend to confirm the rather widely held belief that the Navy has more esprit de corps or service identification than the Army. This is of course also reflected by the history of more successful volunteer recruitment in the Navy. The relatively greater satisfaction of Navy dentists quite possibly may be due to the greater organizational autonomy of the Dental Corps. Free comments by dentists in all federal agencies indicate appreciation of the fact that in the Navy the dentists are subject to far less control by the medical profession.

Evaluation of Measures Proposed and Undertaken

According to our Subcommittee survey, and according to the Navy's own analysis, the major deterrents to volunteer recruitment of physicians are inadequate pay, dislike of regimentation, dislike of administrative work, insufficient opportunity for post-graduate training, dislike of sea duty and the nomadic life, and inadequate housing. (See Appendix 2/11.) Deterrents to recruitment of dentists appear to be similar. An additional one exists in the fear of dentists that they will be transferred involuntarily to another branch of government, a fear which undoubtedly was stimulated by the transfer of a group to the Army last year. Promotion for Navy dentists is claimed also as a deterrent in one respect, since lieutenants (j.g.) have to serve three years before promotion as compared with one year of service for first lieutenants in the Army Dental Corps. (See Appendix 2/14, 2/15.)

Different reasons are given for lack of nurse recruitment. According to the Nurse Corps, young nurses are not attracted by provisions for security. They are concerned, however, to have the eight-hour, five-day week which nurses are striving for and often getting in civilian life. (See Appendix 2/29.)

The pay of regular and volunteer physicians and dentists was increased by $100 a month on 1 July 1947. The Navy feels that this has aided recruitment and caused resignations to subside but that it will probably be necessary to go even further in closing the gap with physician and dentist incomes in civilian life. (See Appendix 2/16.) Under the same law that increased pay it became possible to appoint medical

officers up to and including the grade of Captain. Although this opened up a new field of recruitment, response has been disappointing. (See Appendix 2/13.)

The establishment of post-graduate training programs for Navy physicians, both in service and in civilian institutions, has been considerably emphasized and will continue to receive emphasis. (See Appendix 2/13.) These programs undoubtedly will help to diminish the Navy's manpower problem but they are almost exactly identical with those of the Army and are subject to the same evaluation. This evaluation, which is found elsewhere in this report and in reports of other Subcommittees, raises questions as to the proportion of residents who will remain in service and their willingness to accept transfers from the big hospitals to less attractive posts upon completion of training. Even under the most optimistic conclusion, it would be years before the Navy could meet its specialist requirements through these training programs.

If adequate housing were immediately available to personnel when they report to new stations it is felt that objection to rotation policies would be considerably reduced. Congressional action is desired to provide such housing.

As the Army, the Navy has made certain efforts to answer its personnel shortages by use of civilians only to run into the same types of difficulties. Unlike the Army, however, it has secured the services of 135 civilian nurses and a number of ancillary hospital personnel.

There is indication that the armed services would prefer to reserve many of their medical positions for their own commissioned members and not appoint civilians to them. The Office of the Surgeon General of Navy

states, for example, "that [certain physicians] should be clinicians with outstanding teaching ability in order that an excellent teaching program may be maintained in our teaching hospitals with the minimum number of civilian visiting staff." (See footnote page 63.)

In a previous section of this report it was seen that the Navy justifies its authorized ratio of 6.5 physicians per 1,000 strength to a considerable extent on the basis of the quantity of care given to dependents and other supernumeraries. A similar justification is offered for the request that the ratio of dental officers be increased from two to three per 1,000 strength, and that this strength be computed to include not only active duty personnel but also the supernumeraries themselves, including 46,000 Fleet Reservists and retired personnel, 100,000 natives of the Western Pacific islands, veterans hospitalized by the Navy, dependents, etc. (See Appendix 2/6.)

Similarly it is pointed out (Appendix 2/9) that since the supernumerary patient census in hospitals has risen from about seven and one-half percent in 1916 to about 42 percent at present, there should be an increase in allowance for hospital corpsmen from 15,574 to 22,203. This would be comprised of four percent corpsmen for 1,000 total strength, plus 40 corpsmen per 100 supernumerary patients, plus an increase of dental technicians from 1.75 to 2.00 per dental officer. Hospital corpsmen would thus be about five percent of total Naval strength.

It would seem reasonable to approve of these requests for large increases in the corpsmen if they could be used to replace physicians, dentists and nurses, Such reductions are not planned, however. On the contrary, as pointed out above, a higher ratio of dentists is requested,

and the present ratio of six nurses per 1,000 strength has been in effect for only a few years. Until then the ratio was only half the present one.

In summary evaluation, your Subcommittee agrees with the Navy that its numerical requirements for physicians and dentists, under present authorization, cannot be met without a draft. Even with a draft, and with such other methods as the Navy is using or proposes to use, it is doubtful that physician requirements will be met in terms of quality. The validity of requests for additional ancillary workers is difficult to recognize unless such workers tend to replace personnel with higher professional skill, and so long as they are requested to such an extent for service to supernumeraries. Requests for additional dentists are similarly questionable so long as the Navy's workload has the same components as at present.

## PART V. VETERANS ADMINISTRATION MANPOWER

Personnel Requirements: Quantity

In August 1945 there were about six and one-half million veterans, of whom 77,000 were patients in 97 hospitals. They were cared for by 2,300 physicians, of whom 1,700 were in military status, by 187 dentists and 4,500 nurses.

Three years later (1 July 1948) there were 18,744,000 veterans, of whom 91,290 were patients in 125 VA hospitals. They were cared for by 6,969 salaried physicians with an additional 806 serving on consulting and attending bases. Among the salaried physicians were 2,566 residents. With few exceptions ASTP and V-12 men had completed their tours of duty. The number of dentists had increased to 1,016 and the nurses to 12,397.

It is difficult to compute future additional requirements for personnel for any given year. By and large, however, it is only necessary to assume that the quantity of personnel needed will be in proportion to the beds and other facilities to be staffed. Assuming continuation of present policies, personnel requirements can be estimated roughly to be a third larger upon completion of the present hospital program at the end of 1951, when beds will total approximately 138,000.

On 1 July 1948, with 102,219 operating beds there were 766 positions vacant for physicians, 1,128 for nurses and 26 for dentists. This is almost a 10 percent vacancy for physicians and nurses. Thirty-five hospitals reported a total of 5,184 beds as unavailable for lack

of personnel, including professional employees.

Veterans Administration officials have expressed doubt that personnel can be procured to staff more than 120,000 beds if present employment conditions prevail. There is much reason to believe, however, that many more facilities could be staffed if they were properly located. Experience reveals relatively little difficulty in personnel procurement for most hospitals which are near urban centers, or medical schools. Present vacancies are largely concentrated in facilities which are isolated and have inadequate housing arrangements.

TABLE 13 1/

Medical Personnel in the Veterans Administration
Positions Filled and Vacant by Category and General Field
1 July 1948

| | Positions 2/ | | | |
|---|---|---|---|---|
| | Existing | Filled | Vacant | % Vacant |
| PHYSICIANS - Total | 7,735 | 6,969 | 766 | 9.9 |
| General Duty | 551 | 545 | 6 | 1.9 |
| Specialists - Total | 7,184 | 6,424 | 760 | 10.6 |
| Medicine | 2,078 | 1,870 | 208 | 10.0 |
| Surgery | 1,702 | 1,622 | 80 | 4.7 |
| Neuropsychiatry | 1,577 | 1,324 | 253 | 16.0 |
| Tuberculosis | 352 | 255 | 97 | 27.6 |
| Medical Laboratory | 506 | 448 | 58 | 11.5 |
| EENT | 323 | 297 | 26 | 8.0 |
| OTHER | 646 | 608 | 38 | 5.9 |
| DENTISTS | 980 | 954 | 26 | 2.7 |
| NURSES | 13,525 | 12,397 | 1,128 | 8.3 |

It can be seen on the table above that the present over-all vacancy rate does not reflect the situation with respect to special fields. As has been pointed out by other subcommittees the shortages of physicians in tuberculosis and neuropsychiatry are large enough to constitute serious problems.

1/ For more detailed data see Appendix 33/1-6.
2/ Includes part-time in full-time equivalents. Residents are also included.

Personnel Requirements: Quality

When Public Law 293 created the Department of Medicine and Surgery on 3 January 1946 it became possible, through freedom from Civil Service regulations concerning pay, classification and assignment, to begin to make up the numerical shortages of physicians in the Veterans Administration. The same law, by authorizing 25 percent additional pay for medical specialists, provided a means for making up deficits in quality.

On 1 July 1948 21 percent of the VA physicians were members of the American Specialty Boards. This ratio of one certified specialist to four other physicians compares with a ratio of only about one to five in non-federal medicine.

The proportion of Board members varies from one field to another. Only eight percent of the tuberculosis physicians are certified, which is to a considerable extent due to the lack of a sub-specialty board in this field. In neuropsychiatry there is, as previously mentioned, a shortage in number of physicians but the quality is markedly high, with 26 percent being certified. (See Appendix 33/5 for further details.)

A mechanism which has been useful to the VA in stepping up both the quantity and quality of its medical personnel is the program under which the Deans' Committees operate. Fifty-four of the VA hospitals are now affiliated with medical schools in an arrangement which provides expert civilian consultation for patients, affords residency training for employees and in general stimulates the entire medical program. Over and above this program of affiliation there is an effort to bring private practitioners into the hospitals on fee or per diem basis

where they act not only as consultants but actually aid in carrying the workload. These consulting and attending physicians numbered 806 on 1 July 1948.

Another program which contributes in several ways to quality of medical care is that of residency training. As of 20 August 1948 2,501 physicians were in residence, the maximum that can be accommodated under present budget ceilings. A glance at Table 14 shows that the vacancies have the same unevenness in the various fields as is shown in the full staff. Surgical residencies are extremely popular but there is a seriously deficient interest in psychiatry and tuberculosis. Anesthesiology and neurology are also relatively unpopular. In general these figures reflect the situation in non-federal institutions. (See other Subcommittee reports for full evaluative treatments of this training program.)

The value of this residency training program as a means of recruiting permanent personnel has not yet been established. So far, however, the outlook is favorable. In rough figures, about 400 of the 500 men who have completed their residency training are still on duty.

TABLE 14

Medical Residents in the Veterans Administration
20 August 1948

| | Residencies 1/ | | | |
|---|---|---|---|---|
| | In Program | Filled | Vacancies | % Vacant |
| Total | 2,751 | 2,501 | 250 | 9 |
| Anesthesiology | 100 | 82 | 18 | 18 |
| Dermatology | 22 | 21 | 1 | 5 |
| General Surgery | 558 | 552 | 6 | 1 |
| Internal Medicine | 809 | 781 | 28 | 3 |
| Neurology | 48 | 42 | 6 | 12 |
| Neuro-Surgery | 42 | 42 | 0 | - |
| Ophthalmology | 45 | 45 | 0 | - |
| Orthopedic Surgery | 123 | 123 | 0 | - |
| Otolaryngology | 64 | 63 | 1 | 2 |
| Pathology | 79 | 77 | 2 | 2 |
| Physical Medicine | 14 | 8 | 6 | 43 |
| Plastic Surgery | 5 | 5 | 0 | - |
| Psychiatry | 616 | 450 | 166 | 27 |
| Radiology | 112 | 106 | 6 | 5 |
| Thoracic Surgery | 23 | 21 | 2 | 10 |
| Tuberculosis | 23 | 16 | 7 | 30 |
| Urology | 68 | 67 | 1 | 1 |

1/ These figures were prepared by Special Boards, Department of Medicine and Surgery.

Personnel Requirements: Motivation

Job satisfaction among physicians and dentists in the Veterans Administration appears to run considerably higher than that in the Armed Forces and, in some respects, higher than in the Public Health Service, according to our Subcommittee survey. (See Appendix 50.)

The job attitudes of nurses are quite similar in all agencies, due largely to the fact that they are volunteers in the Armed Forces as well as in the civilian agencies. According to their present plans, however, the high turnover rates in nursing staffs will continue, with only one out of every five or six intending to remain very long in their present agencies.

In Table 15 it can readily be seen how the character of service differs for physicians and dentists in the civilian agencies from that in military agencies. In the VA there is relatively little change of duty or station. Nor is there much change of duty for PHS dentists in our sample. The PHS physicians reported substantial amounts of change both in duty and station, and the dentists in this agency reported frequent changes of station.

An examination of free comments on the questionnaires indicates a number of reasons why personnel have left the VA and the PHS and why others are considering leaving. Despite the present higher rates of pay, low income is one of the most frequent complaints. Four out of every ten physicians recently separated from the VA gave this as their chief reason. Among those still on duty, 15 percent express this complaint. Among those still on duty in the PHS as well as among those recently separated, 15 percent give this as their principal complaint.

TABLE 15

Comparisons of Job Attitudes Between Medical Personnel in Army, Veterans Administration and Public Health Service

| | Physicians | | | Dentists | | | Nurses | | |
|---|---|---|---|---|---|---|---|---|---|
| | Army | VA | PHS | Army | VA | PHS | Army | VA | PHS |
| Percent of sample saying their professional skills are being used "very well" | 43 | 64 | 66 | 59 | 73 | 66 | 51 | 58 | 47 |
| Percent saying they are "very well" satisfied with present assignments | 46 | 57 | 55 | 51 | 58 | 54 | 53 | 50 | 49 |
| Percent saying that in general they liked their work as a "professional person very well" | 42 | 60 | 54 | 55 | 81 | 65 | 83 | 64 | 71 |
| Percent saying their type of duty had been changed "substantially" at least twice in previous twelve months | 22 | 4 | 9 | 8 | 4 | 2 | 22 | 18 | 13 |
| Percent saying they had changed station at least twice in previous twelve months | 21 | 3 | 7 | 8 | 1 | 13 | 11 | 4 | 4 |
| Percent of separatees who, if required to return to government service, would choose to return to same agency 1/ | 27 | 31 | 68 | 13 | 20 | 72 | 61 | 22 | 60 |
| Percent of duty personnel who plan to remain in agency "until retirement" or "indefinitely" | 24 | 85 | 72 | 37 | 67 | 45 | 17 | 17 | 20 |

1/ The survey included samples of recently separated physicians, dentists, and nurses as well as those on duty.

Among physicians recently separated from service, both in the VA and the PHS, about one in every three or four complained about their lack of opportunity for good training and professional experience.

Changes of station seriously bothered about a fifth of the PHS physicians.

Among dentists dissatisfactions leading to resignation or thought of resignation were similar to those reported by physicians. In the VA, 60 percent mentioned low income; 15 percent, lack of good training under competent seniors; and 5 percent, promotions slow and unfair. In the PHS, the possibility of transfer and consequent housing difficulties brought a 39 percent complaint, and low income 34 percent.

Possibly because fewer nurses than physicians and dentists plan permanent careers in their present employment, their complaints were fewer and seemingly less intense. In the VA the most frequent objection was that concerning lack of chance to practice their special skills. Thirteen percent mentioned this, and 9 percent complained about having little chance for advancement. Both of these points were made by PHS nurses, though less frequently.

Measures Undertaken

To outline in detail the many steps taken by the Veterans Administration to cope with its huge new task after the war would be to document the obvious. The history of the major personnel reform which was at the core of the agency's reorganization is widely known in medical and health circles.

Ignoring measures of secondary importance, there were five basic features of this reform: the passage of Public Law 293, affiliation of hospitals with medical schools, establishment of residency training programs, the borrowing of ASTP and V-12 personnel from the Army and Navy, and a continuing program for shift of the workload from full-time staff to part-time consultants and practitioners.

Under Public Law 293, 79th Congress, physicians, dentists and nurses in the VA were exempted from Civil Service regulations and it became possible to appoint and promote them principally on the basis of their qualifications and not in accordance with their ages or the jobs to which they were assigned. This flexibility, plus 25 percent additional pay for certified medical specialists, enabled the VA to secure large numbers of personnel who were en route from war-time military service to private practice. Additional numbers were attracted from civil practice. (For further details about Public Law 293, see msc-39.)

The agency's requirements for personnel swelled so rapidly, however, that other measures had to be taken. One of these was procurement from the Army and Navy of 1,500 ASTP and V-12 physicians who served from the summer of 1946 until July, 1948. While this move was clearly an expedient, it partially relieved the VA from immediate pressure and gave it time to inaugurate more permanent recruitment programs.

The latter included affiliation with medical schools, through the Deans' Committees which were cooperatively arranged, and the establishment of an extensive residency training program. These moves, perhaps more than others, have served to raise the level of medical care in the VA to a point where it receives general approval from the medical groups of the country. One effect of this has been a widespread stimulation to recruitment. In addition, it is expected that training programs will prove to be a direct recruitment device by procuring the extended services of those who go through this residency training.

Also of extreme significance was the program inaugurated for employment of large numbers of part-time personnel. This is a reversion to the standard practice of non-government medicine. Moreover it is a move which recognizes the near impossibility of providing highly specialized and totally rounded services by full-time staffs without expanding such staffs to unjustified and extravagant proportions. On 30 June 1948 the VA had almost 3,000 part-time salaried, fee basis and per diem physicians. The services of these, plus services of the residents, can be estimated to reduce the requirements for full-time salaried physicians by perhaps a third.

Were it not for adoption of all of these programs the VA could not have even approximated its present medical service in either volume or quality.

Measures Proposed

The success of the VA in shouldering its post-war burden has been in many instances likened to a miracle. The medical care of World War II veterans has only begun, however, and will not be finished in this century. Already, only three years after the war, the psychological climate of V-Day has changed and programs for veterans have become a part of the general long range task of government. The VA medical care program, which received wise direction and widespread acclaim and support, has not yet been able to meet the demands made of it, and these demands, under present policy, will more than double in volume in the next few decades.

Personnel shortages have persisted despite the measures undertaken. Personnel morale problems accumulate.

Official statements from the VA indicate there are many serious personnel problems. Those revealed in the Subcommittee survey, and others, have been recognized and attempts are being made wherever possible to solve them. Some of these problems reported to the Subcommittee are as follows:

In medical personnel recruitment there is considerable competition among the various government agencies. This is reflected in the statement that "There is but a limited and unknown number of doctors, dentists and nurses who will consider federal employment during times of plenty. [For these] this agency has keen competition with the Armed Forces, for while VA salary ranges in the higher grades for doctors and dentists are slightly advantageous . . . . such is not the case with nurses. [Moreover] the Armed Forces aside from the stated base salary provide many features not available to the Department of

Medicine and Surgery (VA) employee such as: lower income taxes . . . medical and dental care for employee and dependents . . . housing provisions for the most part in Armed Force stations . . . commissary privileges and full retirement at three-quarters base pay for line of duty permanent disability."

The above statement not only describes inter-agency competition, but also reflects it. P.L. 293 made it possible for VA better to meet the attraction of other agencies. Since then, 3 January 1946, however, Armed Force physicians and dentists have received pay increases, and the VA feels that it is once more at a partial disadvantage. As a result of this feeling, it will seek pay increases and it will also pursue "an aggressive recruitment program" outlining the features of the VA which are superior to those of other agencies. "Approved pay legislation [i.e. increases] would greatly enhance recruitment for the Department of Medicine and Surgery." (See Appendix 33/8,9,11)

Location of hospitals and other medical care facilities in the VA would appear to be probably the most important deterrent to recruitment. It is well established that qualified applicants, unless they live in the same area, are not attracted to isolated stations and medical units of the regional offices. This is a continuing problem, since the closing of such facilities would frequently mean withdrawal of service. Young, well-qualified persons have been especially intolerant of such assignments and by necessity these positions have had to be filled with many older and less-well-qualified men. Housing problems tend to be greater in these isolated places, adding a further deterrent. The possibility of a housing construction program has been explored by the VA but there is little hope of much being done. VA officials feel that

the staffing of isolated stations will become less of a problem as medical personnel accumulate larger stakes in their careers and become more willing to accept sacrifices for the protection of career interests. (See Appendix 33/7)

There is reported a certain amount of dissatisfaction with regimentation in the VA program. The agency feels, however, that their present efforts to streamline administrative procedures will cause such complaints to drop off.

The problem of securing certain medical specialists, such as psychiatrists and tuberculosis men, is clearly recognized by the VA. These shortages reflect conditions which are general throughout the country, however, and aside from constant pressures toward staff recruitment and residency programs, the VA sees little it can do to solve this problem.

Many personnel are lost by the VA to schools, clinics and other institutions. This problem, again, is one for which there appears no easy solution. VA officials feel that such personnel are attracted largely through their professional interests and that the only hope of holding them is to maintain the constant effort to achieve maximum standards in medical care, teaching and research.

The program to employ the maximum number of part-time personnel, for medical care as well as teaching, is still emphasized in the VA. "The problem of staffing our hospitals will become acute within the next few months. As one means of meeting this problem it is now being planned to transfer qualified full-time physicians other than key personnel from regional and sub-regional offices to hospitals, and to replace them with part-time physicians sufficient in number

to handle the case load and to cover the various specialities." The general feeling is that great reliance must continue to be placed in all parts of this program for part-time personnel employment.

In an effort to conserve the quantity of personnel and to facilitate proper utilization of specialists, the VA is now in the process of preparing manning guides which correspond to some extent with Tables of Organization in the Army. "Studies are in process to find usable criteria for determining the number of physicians, dentists and nurses required according to the number of staff and fee examinations and treatments." While it is suspected that over-reliance on Army T/O's has often led to wastage of personnel resources, it must be recognized that in any massive personnel system staffing patterns are necessary and that, if not formally designed and approved, they will be developed in some fashion anyway. Budget Bureau allocations for the VA have in effect been based upon informal manning guides, since they involved bed-professional employee ratios. Since it is said (Appendix 33/13) that these ratios "do not necessarily reflect Department of Medicine and Surgery recommendations" it would seem well for the Department to proceed with development of its own manning guides in the hope that means of personnel conservation will result.

Evaluation of Measures Undertaken and Proposed

Analysis of the medical care program in the Veterans Administration, and of the relationship between this program and those in other government agencies, suggests four major problems which require serious consideration. These concern inter-agency competition for personnel, use of part-time personnel, location of hospitals, and personnel procedures (e.g. P.L. 293).

Inter-agency competition for personnel. There is little doubt that the recent growth of the Veterans Administration medical program accounts for its share of the present intensified competition between agencies for medical personnel. Its extensive requirements, its recognition of and compensation for special qualifications, and its new flexibility in personnel appointment, classification and promotion, has given this agency a number of strong attractions for persons who might otherwise be in the Army, or in another government agency or on the staff of state or other non-federal institutions. As other agencies get authority to step up their inducements the Veterans Administration begins to lose its advantages and is forced to recoup them by still further offerings.

With respect to pay increases, for example, it is not the intent of your Subcommittee to make negative recommendations for the Veterans Administration. If we grant the assumption put forth, however, that there is only a certain group of medical personnel who will accept government employment, and that this group is not large enough to meet the total needs of government, we necessarily must doubt the wisdom of having five independent medical recruitment programs which automatically

create the bidding procedure of an auction market. It is recognized that salaries must accord with living costs and must compete with those offered outside of government. Yet bidding between agencies which does not increase the total number of persons who will enter government service must be criticized.

It must be recognized that competition exists not only with pay but with a whole series of complicated inducements and emoluments, including retirement privileges, various sets of perquisites with monetary value, opportunities for post-graduate training, assurances of special assignments, etc. There is competition moreover for affiliations and other arrangements with medical schools, for specialized consultants, and for all types of part-time personnel.

The tendency of this inter-agency struggle to circle and spiral through rapidly changing inducement programs is one for which your Subcommittee can suggest no solution as long as the present system remains. Each agency has little alternative but to try to meet the bids of its rivals. It can be expected, therefore, that the problem will remain until the government system is changed toward unification or toward greater concentration of its medical programs.

Use of Part-time Personnel. It is our belief that the Veterans Administration has satisfactorily demonstrated many important advantages in providing federal medical service through the use of part-time personnel and in abandoning the attempt to render this service entirely through full-time staffs. Movement in this direction seems to be demanded not only by the present need to conserve scarce skills and by the contribution to better medical care which this arrangement affords. As medicine grows more complex, it is probable that society

cannot afford the heavy burden of educating personnel who are not utilized as widely and flexibly as possible. This undoubtedly will require more and more integration of hospitals with their surrounding communities and will permit the existence of few hospitals which are strictly self-contained and totally staffed from within.

As pointed out above, however, the use of part-time personnel by several government facilities in the same area intensifies the problem of inter-agency competition. Both the Army and the Navy have reported difficulty in securing part-time assistance due to personnel being already obligated to the Veterans Administration or another government agency.

Location of Hospitals. Much of the Veterans Administration's problem in procuring medical personnel is undoubtedly of the government's own creation. The Army and Navy are limited to some extent in their freedom of location of most of their facilities, and are completely limited with respect to some of them. Some hospitals must be overseas, for example, and others must be in isolated maneuver areas. There is less justification for Veterans Administration hospitals to be located in isolated areas and it can safely be predicted that personnel procurement will continue to be a problem in these facilities at all times except during economic depression.

It has been explained that savings were effected by using facilities constructed by, but no longer needed by, the Army, and that some of these happened to be isolated. An examination of the Veterans Administration's program shows, however, that even some of the new hospitals are being constructed in isolated areas.

It can be seen that such location not only inhibits full-time staffing but makes it difficult to secure the services of part-time personnel.

Assuming shortages of medical personnel for some time to come it is necessary to conclude that facilities and patients must to a greater extent be moved to where the personnel are.

Personnel Procedures. Much of the Veterans Administration's success in rapid accumulation of personnel has been due to Public Law 293, and if there is to be unification of federal medical services it would seem necessary to incorporate some of the basic features of this law into the governing personnel policy of the unified agency. Experience has revealed several flaws in this law, however, some of these the Veterans Administration is attempting now to correct. There are in addition several provisions requiring further consideration before their use is extended.

Due to large numbers of vacancies on the staff there has been ample flexibility for rapid promotions. And because of the newness of the system, the problem of releasing older persons and persons of lesser competence has not yet developed fully. Thus it can be argued that the system has not received a full test of its effectiveness and cannot be assumed to work permanently as well as it has appeared to work during its first three years.

Further consideration should also be given to the provision for extra pay for medical specialists. Since certifying boards do not exist in several medical fields, nor in the fields of nursing, dentistry and other health professions, the possibility should be explored of

devising means to reward unusual qualifications which are less arbitrary and which can be applied more broadly.

Provision may be necessary also for automatic promotion of personnel through a certain number of grades.

## PART VI. PUBLIC HEALTH SERVICE MANPOWER

Introduction Among the five major medical agencies in the federal government, the Public Health Service is the only one in which health activity is the sole and primary mission. With somewhat less interest than other agencies in routine provision of medical care and with more interest in development of public health procedures, in health education, experimentation, and research, the program of the Public Health Service is a composite of services, activities and projects which is difficult to characterize as to "workload". With the possible exception of its hospital program, this agency's functions are difficult to compare with those of other agencies. In addition to its 21 general, two tuberculosis and two psychiatric hospitals, the Service operates 21 out-patient clinics, 219 foreign quarantine stations, and several employee health programs, conducts control programs such as that in venereal disease, runs the national office of vital statistics, details professional personnel for the staffing or direction of various government agency medical care programs, "loans" key personnel to health programs operated by the states or other non-profit groups, and administers research institutes. Due to the heterogeneous nature of these and many other activities, the manpower problem of the Public Health Service does not lend itself so readily to analysis as those of other agencies.

Some idea can be gained of the extent to which the Public Health Service is "routine" if we assume that for the most part hospital service falls in this category and that the other activities are

justified principally on their merit as research, teaching and education programs. Roughly a half of all personnel are in hospital service. This includes about a third of all full-time physicians, four-fifths of the nurses and three-fourths of the dentists. Non-hospital services are therefore somewhat more professional in nature requiring two-thirds of the physicians.

There is another outstanding respect in which this agency's personnel structure is unique. Of 17,041 persons employed on 31 July 1948, 2,148 were in a commissioned corps which can be likened in all major respects to those of the Army and Navy. The principal difference is that in the Public Health Service there is no "line command" or other non-medical group in higher control. It is in effect, therefore, an autonomous medical corps. The corps includes about four-fifths of all the physicians in the agency, virtually all of the dentists and sanitary engineers, a third of the nurses, and varying proportions of several of the smaller categories of health personnel.

Personnel not in the commissioned corps are under Civil Service, thus forming a dual system in which the dichotomy extends even to the point of having separate personnel offices.

Personnel Requirements: Quantity and Quality

Despite the opinion held by many that it is the best government agency for a professional person to work in, an opinion which was borne out in part by the Subcommittee survey (See Appendix 50), the Public Health Service has been unable to recruit physicians in the numbers needed. Recruitment of dentists and nurses has been sufficient to meet minimum needs but new programs assigned by Congress have created requirements for physicians faster than they could be filled. The authorized strength for physicians increased by 216 between 1945 and 1948 while the active strength increased only by 60. In Table 16 it can be seen that the recent vacancy for physicians was 12.5% as compared with 5.7% for nurses.

Table 16

Medical Personnel in the Public Health Service
Availabilities and Requirements - Quantity

| | 1 July 1940 | Positions (31 July 1948) | | | 1 July 1950 |
|---|---|---|---|---|---|
| | On Duty | Filled | Vacant | Total | Required |
| Physicians - Total | 719 | 1289 1/ | 184 | 1473 | 1502 |
| Commissioned | -- | 1043 | 169 | 1212 | -- |
| Civil Service | -- | 246 | 15 | 261 | -- |
| Dentists - Total | 137 | 202 | 35 | 237 | 314 |
| Commissioned | -- | 199 | 35 | 234 | -- |
| Civil Service | -- | 3 | -- | 3 | -- |
| Nurses - Total | 906 | 1951 2/ | 117 | 2068 | 2161 |
| Commissioned | -- | 473 | 74 | 547 | -- |
| Civil Service | -- | 1478 | 43 | 1521 | -- |

1/ Includes 134 interns but excludes 1440 part-time and intermittent physicians.

2/ Includes 109 cadets, 9 practical and 58 Philippine nurses.

Data are not available showing Public Health Service physician vacancies by specialty. According to its calculation of requirements for 1950, however, its needs for specialists in medicine, psychiatry and preventive medicine and public health will be considerably greater than could be filled by present personnel.

Table 17

Physicians in the Public Health Service
Availabilities and Requirements - Quality

| | Available 31 July 1948 | | | Required 1 July 1950 |
|---|---|---|---|---|
| | Certified | Not Certified | Total | Total |
| Physicians - Total | 33 | 1256 | 1289 | 1502 |
| General Duty | -- | 549 | 549 | 487 |
| Specialists | 33 | 707 | 740 | 1015 |
| Medicine | 7 | 147 | 154 | 248 |
| Surgery | 7 | 140 | 147 | 167 |
| Neuropsychiatry | 7 | 60 | 67 | 116 |
| Tuberculosis | — | 54 | 54 | 54 |
| Laboratory | 9 | 116 | 125 | 129 |
| EENT | 3 | 21 | 24 | 28 |
| Preventive Medicine and Public Health | — | 140 | 140 | 242 |
| Others | — | 29 | 29 | 31 |

Evaluation of Problem

The Public Health Service reports that the basic factors affecting its procurement are the same as those for other agencies and employers, namely, the competitive disadvantage in government salaries and the present widespread disparagement of federal employment, especially with regard to scientific personnel. Motivation and morale of PHS employees was discussed in PART V, along with that of Veterans Administration personnel. Several factors in the PHS personnel situation are peculiar to that agency, however, and call for our separate consideration.

One is the different nature of its personnel shortages. With a program somewhat less devoted to clinical work than that of other agencies, it suffers from the insufficiency throughout the country of such specialists as doctors of public health and preventive medicine and public health engineers. All personnel in the mental health fields, including psychiatric social workers, fall short of requirements. Attributing these shortages in large part to inadequate educational facilities the PHS recommends a "multi-lateral program of leadership and financial aid to professional education".

Since the Veterans Administration organized its own system for medical personnel the PHS is the largest user of Civil Service personnel. It reports many of the difficulties formerly encountered by the VA. "There is need for more flexibility in many aspects of the Civil Service system. Eligibility standards should be more adaptable to local circumstances. Promotion is restricted by imposition of rigid time requirements even in cases of excellent performance. More flexible provision should be made for advance to compensate high level

performance without the necessity of adding supervisory duties. Classification procedures need to be simplified and made more responsive to practical administrative needs." It is indicated that the PHS would be unable to perform its missions with present proficiency if it had to operate entirely within the Civil Service system and did not have the flexibility and autonomy afforded by its commissioned corps system.

The commissioned corps has been sharply criticized by the Budget Bureau on the grounds that it builds up class prejudice, controverts our democratic customs by establishing and sponsoring a caste, and encourages a belief in special privileges, as represented by the benefits and allowances received by commissioned officers. The PHS would not subscribe whole-heartedly to the validity of some of these criticisms but it does admit that the corps creates certain morale problems, especially where employees such as nurses may be assigned to the same work and yet have differential status and advantages. While PHS officials believe that on the whole the two parts of the dual personnel system are fairly well harmonized, they do not deny the possibility that some new uniform system might be better if it preserved some of the advantages of the commissioned corps and eliminated some of the weakness of the Civil Service System. ". . . in working out any change it is imperative that the adaptability, the career aspects and other morale building factors of the commissioned corps be preserved. Especially for professions most definitely identified with public health work it is essential to have a personnel

scheme more realistically geared to job requirements, and to competition with industrial and university opportunities, than the present Civil Service system." (Appendix 34/2)

The experience of the PHS during World War II has led to consideration of steps which might be taken to assure the various government agencies and other employers of an equitable supply of medical personnel in time of future emergency. Although Regular Corps Officers, and Reserve Corps Officers on extended active duty, are not subject to activation by the military services in time of war, replacements and additional personnel are extremely difficult to procure. Consideration of the problem of maintaining vital public health work and of continuing important research in time of war has led the PHS to the following conclusions:

> "The establishment of a policy and mechanism for the equitable distribution of the limited supply of medical services personnel, in the event of a war emergency, is imperative. If the medical care requirements of all segments of the population - military, industrial and civilian - are to be met, no agency or activity can be permitted unlimited priority in the requisitioning of medical personnel.
>
> "It would seem advisable that the determination of relative needs of various groups for medical personnel and the apportionment of this personnel among the groups rest with an independent civilian agency. In addition to assuring equitable allotment of the existing supply provision should be made for maintaining the supply through deferment of students in the medical sciences. Such deferment should not be made contingent upon a commitment at the time of deferment of the individual student to obligated service with a specific agency or activity. The field of obligated service, it is felt, could be determined more effectively at the time of completion of professional training and in the light of the then existing conditions.

"One field of activity most likely to be affected adversely by a war emergency would be that of basic research. Experience has shown that research activities would be directed to the immediate solution of war-born problems. Both the organic research of the Service and that carried on through Service sponsorship by means of grants-in-aid, would be affected. Operating programs less directly related to the war emergency would also suffer. Among these would be those public health programs concerned with the diseases and disabilities of middle and advanced age such as cancer control and heart disease control programs. Other long range programs such as that for the abatement of water-pollution doubtless would have to be curtailed to accomodate for the more immediate problems of emergency health and sanitation activities."

## PART VII. ANALYSIS OF FEDERAL MANPOWER PROBLEM AS A WHOLE

Reduction of Workload

The volume of medical care which the government is committed now to provide, either under legislative or executive authority or through the growth of tradition, is not basically a part of the manpower problem which this Subcommittee has studied. Definition of beneficiaries who are entitled to care is a matter of legislative decision or approval rather than a problem of organization.

Since the problem of paramount importance in government medical service is that of procurement and retention of personnel, however, it seems necessary to consider the extent to which present medical personnel are engaged in the care of those classified as secondary beneficiaries, and of primary beneficiaries whose need for care has diminished through changes in the conditions which originally led to their medical privilege.

Notable in the latter group are merchant seamen, who are estimated to form about half of the workload of the Marine Hospitals in the Public Health Service. It cannot be assumed that a 50 percent reduction in workload would permit an equal reduction in staff. If so it could be estimated roughly that 300 physicians, 60 dentists, 700 nurses and corresponding numbers of ancillary workers could be reassigned.

In the Armed Forces the largest item in the secondary workload is care of dependents. Considering this with the care of others, the Navy reports that "40 percent of Naval Hospital patients are super-

numeraries" are not active duty Navy or Marine Corps personnel. "An average of 100,000 out-patient consultations and visits are made each month. It is estimated that service provided for extra beneficiaries increases the primary workload by 25 percent". Our estimates indicate that 250 medical officers, and corresponding groups of other health personnel, could be reassigned if dependents' care were discontinued.

The secondary workload in the Army and Air Force is more difficult to compute since personnel records are not designed to show exactly which nor how many persons are assigned to or engaged in this function. The Office of the Surgeon-General estimates that if all dependents' care were discontinued the requirements for medical officers would be reduced by only 150, or less than three percent of all net requirements. While it is more difficult for this Subcommittee to translate workloads of such nature into personnel requirements, it estimates conservation of physicians to be in the neighborhood of 335.

The argument might be granted that the Armed Forces could not discontinue dependents' care without breaking "contracts" with its present personnel and without seriously hampering its future recruitment of other personnel. It is essential to point out, however, that unusual implications are contained in maintenance of these programs under the conditions now faced in procurement of medical and dental officers. Until recently medical personnel who provided dependents' care had entered service voluntarily, thereby agreeing automatically to perform any service assigned. This is not the situation at present when thousands of physicians and dentists have been obligated to serve

as a result of participation in the ASTP and V-12 programs. Nor would it be the situation if authority is granted to draft medical and dental officers. The argument that the morale of a soldier overseas is bolstered by assurance that his wife back home will be delivered competently and without charge by an Army obstetrician must now be weighed against a counter argument, namely that the morale of the obstetrician may suffer under the authority of an agency which can compel him to leave private life and perform work which is not directly connected with the primary mission of that agency. The decision as to maintenance of discontinuance of dependents' care does not fall within the province of the Manpower Subcommittee. Provision of such care by personnel who are not voluntarily recruited does constitute a problem in manpower, however, and the subcommittee believes that its solution calls for consideration of other arrangements.

The same dilemma has arisen in the care of veterans, 6,244 of whom were distributed among Army and Navy hospitals on 30 June 1948. Although these veterans are often service-connected, the beds they might occupy in Veterans Administration facilities are now used for those who are not service-connected. In effect, therefore, the Army and Navy now propose to draft medical personnel to care for patients whose entitlement to this privilege is only permissive and not a full obligation of government.

It is not possible to compute the reduction in personnel requirements which would result from discontinuance of the medical services now given to veterans without service-connected disabilities. Even assuming that chronic care would not be withdrawn, however, savings of physicians might total 1,000. Savings of nurses and others would be proportional.

Intra-Agency Utilization

The Basis for Determination of Requirements.

Because of the numerous and disparate functions of the Public Health Service and because of incomplete implementation of the medical care program in the Veterans Administration the subcommittee has not undertaken the special studies necessary to establish the effectiveness with which personnel in these agencies are utilized. For a number of reasons, however, we have felt it necessary to give some consideration to the problems of utilization in the Armed Forces. In view of the special measures which have been proposed to procure medical personnel in large numbers for military service, and in view of the opinion widely held among Medical Corps veterans that these agencies are extravagant with their professional personnel resources, such consideration is demanded.

The outstanding feature of Army and Navy methods for establishing personnel requirements is that they are based upon successions of empirical judgments. No record has been found of a scientific and objective study to decide minimum and maximum needs of professional skills for given workloads. (See Appendix 40.) A request to Congress for physicians is determined in total number by addition of the various numbers requested by different types of installations and by those responsible for certain special functions. The total number is theoretically adjustable in the agency's higher echelons in the light of broader policy considerations, and upon the advice of civilian consultants, but in actual practice the proportionate strength requested, and that finally authorized by government, is quite constant from year to year, and from war to peace. In war,

the potential demand for care of battle casualties maximizes the need for physicians. In peace, the necessity to provide care for widely dispersed contingents of soldiers and sailors serves, it is said, to prevent reductions below the wartime physician-workload ratio.

It is not completely clear why differences exist in calculations of requirements between the Army and Navy. The Army does not have a legal physician-workload ratio, whereas that in the Navy is established by law at 6.5 per 1,000 total strength. The number of physicians for which Congress actually appropriates funds may be somewhat lower than 6.5, however, and the ratio finally utilized is that authorized by the President, which may not exceed the appropriated strength. The Army refrains from the use of such ratios, in the belief that ratios established as ceilings tend to become floors by relieving hospital and unit commanders of the necessity to base their requirements upon actual rather than theoretical needs. Under present tentative plans, however, the Office of the Surgeon General computes a "gross requirement" figure of 7.2 instead of the Navy's 6.5.

In terms of net requirements (excluding requirements for residents and for position vacancies in the striking force) the Army's need is tentatively stated at seven physicians per 1,000 strength. This does not include the Air Force, for which the need is three per 1,000. The wide difference between these figures is explained by several functions in the Army with which the Air Force is not burdened, including general hospitalization, residency training programs, induction and separation examinations, a heavier supply of service to veterans and dependents,

and central overhead. The principal medical functions in the Air Force are care of troops and comprehensive care up through the station hospital level, both of which are more clearly identifiable with the primary mission of the agency than are some of the functions in the Army.

In discussion of the bases upon which the military agencies establish their personnel requirements, it is recognized that no methods exist for utilization measurement. The "out-put" of a physician, dentist, or nurse in the Army cannot be gauged any more readily than in civilian life. Both the Army and Navy could conduct experiments in differential staffing, however, without becoming involved in complicated procedures of job analysis. If such experiments were carried out with the assistance of research specialists and under the guidance of objective medical consultants from civilian life, the criticism on this point would be, to a considerable extent at least, either allayed or justified and corrected.

It does not seem that a government agency can afford the continued existence of misunderstanding of the premises it uses to calculate the facilities or the personnel it requires. Nor is it strange that a lack of understanding of these premises exists when the use of ratios cannot be traced back to definitive studies and can be explained only historically, when these ratios have remained relatively fixed throughout the period since the National Defense Act of 1916 despite what would apparently be relevant and significant developments in the case and scope of transportation, in diagnostic procedures, in professional techniques, and in effectiveness of drugs and medicines.

It is not unreasonable to believe that military medical services, through the peculiar nature of their supporting mission, would have to employ formulas and ratios in computing personnel requirements. What is important is that ratios must not be discarded but rather that they must not remain rigidly fixed through changes in circumstance. Experience in the Mediterranean Theater during World War II demonstrated that even with heavy battle casualties the supply of medical personnel could be permitted to drop below five per thousand strength when these were assigned and utilized effectively and when use was made of lay administrators. (See Appendix 41.) According to the Army's present planning figures, no considerable shift in workload to lay administration is contemplated. Requirements for 30 June 1950, as compared with current requirements, involve increases of 34 percent and 40 percent in the Medical and Dental Corps, and lesser increases of 21 percent and 30 percent in the Medical Service and Nursing Corps. A recent medical observer in Europe, commenting on non-professional duties, said that property accountability alone requires two to four days a month of a medical officer's time. (See Appendix 51/12.)

Personnel Costs of Federal Policy of Maximum Medical Care. The practice followed by the federal agencies in providing their beneficiaries with maximum medical care accounts for an indeterminable addition to personnel requirements. The abbreviated table below shows relative differences in the stay of patients in different hospital systems, both federal and non-federal.

LENGTH OF STAY IN DAYS FOR SELECTED OPERATIONS

| Type of Operation | Hospitals | | | | |
|---|---|---|---|---|---|
| | | Federal | | | |
| | Non-federal | PHS | VA | Navy 1/ | Army 1/ |
| Appendectomy | 7.8 | 11.9 | 15.4 | 20.3 | 19.6 |
| Tonsillectomy | 1.4 | 6.8 | 14.8 | 13.3 | 16.1 |
| Hemorrhoidectomy | 6.9 | 11.8 | 33.4 | 25.7 | 27.3 |
| Herniotomy | 10.3 | 16.0 | 26.8 | 28.1 | 29.4 |

1/ Active duty personnel in general hospitals.

It is said that in the Armed Forces patients cannot be discharged as early as in civilian life because no provisions exist for their convalescent care, necessitating their retention in hospitals until they can return to duty. Such reason does not exist to the same extent in Public Health Service and Veterans Administration hospitals, however, which also keep patients considerably longer than civilian institutions.

Even in the Army, for example, it is unrealistic to believe that the medical personnel required for care of one herniotomy case for 29 days is as great as that required for three such cases discharged at the end of 10 days. If 19 days of the 29-day stay of one such case is chargeable to administrative functions and to housekeeping or convalescent service, rather than to the need for strictly professional attention, it would be expected that this less professional

care would be reflected in relatively low requirements for physician personnel. Requirements are computed in accordance with the number of beds available, however, and not in accordance with the professional attention needed by the patients. There is no indication that the federal hospitals, in their attempts to lower personnel requirements to compensate for prevailing shortages, have taken this factor fully into consideration.

Professional Personnel Savings Through Use of Ancillary Workers. By law and by medical school regulation the post-high-school education of a physician consumes from seven to nine years, including premedical training and internship. By present custom more than two years are spent on the average in additional residency training before what may be termed as full occupational status is achieved as a salaried or self-employed physician. During recent decades the time required for education of dentists and nurses has lengthened in comparable fashion.

It is possible that the education of medical personnel may become still more complex and lengthy, but it is already necessary to face the realization that society cannot support the time and money investments of present magnitude unless the skills acquired can be fully recaptured through utilization and efficiency. There is undoubtedly a limit to the number of persons who can be provided such skills, and the services of the relatively few who will have them must be made available with maximum frequency and to patient loads of maximum size. Efforts to proliferate these specialist services through the use of ancillary personnel, in the opinion of your Subcommittee, have not

received sufficient emphasis. Wherever possible the highly trained or experienced professional must be employed as director of, or consultant to, a team of less qualified personnel rather than as a lone practitioner. This is essential during times of personnel shortages but, in order to spread the heavy outlay for education and thus to reduce the costs of medical care, it is a necessary management practice at all times.

It perhaps cannot be said that professional personnel in federal service make less use of ancillary personnel than do physicians, dentists and nurses in non-federal medicine. This is a problem, however, in which the government might well lead instead of follow. By doing so it would not only come closer to solution of its own personnel shortages. It would, through demonstration of the management patterns it develops, encourage conservation of professional skills throughout the nation as a whole. The government not only has a stake but an obligation in this development of ancillary work, since its medical service programs are conducted in systems in which experimentation is easier than in private medicine, where the tradition is predominantly that of individual practice.

Moreover, there is certain knowledge that professional personnel are never adequate in numbers when an emergency occurs, and are likely to be even more inadequate in the next war if its character is what we expect. Since it always becomes necessary, therefore, for professional persons to transfer many of their duties to sub-professional and non-professional assistants, it seems only reasonable that preparation for emergency demands continuous training of such assistants.

No implication is intended that government agencies are not moving in the direction indicated. Examples of such movement are numerous. The effectiveness of well-trained pharmacists' mates in the Navy is widely recognized and the value of the Navy's Hospital Corps in general has been proven. The Air Corps is conducting courses in differential diagnosis and first aid for enlisted men to be assigned to small outposts where the workload does not justify the presence of a doctor. During the war the Army successfully trained WACS as practical nurses and now is renewing the training program by an experiment in one of its large hospitals. The Navy has similar plans for some of the WAVES. Many technicians, such as those in X-ray, are developed in the agencies through on-the-job training. The Veterans Administration trains many types of technicians to do work which formerly was done either by physicians, dentists and nurses or not done at all. In the military agencies, efforts to shift non-professional duties to technicians and administrators trained in the service corps have been continuous.

The collective results of all these efforts, however, in terms of actual replacement of physicians and other expensively trained professional personnel, have not been impressive. The numbers of physicians, dentists and nurses required for given workloads are as great or greater than they were before trained assistants were available. For example, despite the effectiveness of its Hospital Corps, the Navy now requests six nurses per 1,000 strength as compared with half this number a few years ago. The Army requests more personnel for its Medical Service Corps than ever before, but its requirements

for physicians have not dropped. One explanation for this is the undoubted fact that patients are receiving better care than ever before, that is, that the addition of assistants to medical staffs has provided service to patients which, either in kind or quantity, they did not receive before. For example, the occupational therapist does not necessarily serve as a partial substitute for physician or nurse but renders a service that is new and additional.

Whatever the reason is for the partial failure of ancillary workers to relieve professional personnel, the fact remains that the professional persons still feel they are performing duties which could be taken over by assistants of one sort or another. This was revealed by the questionnaire survey conducted by the Subcommittee. (See Appendix 50.)

TABLE 18

Amounts of Non-Professional Work
Which Could Be Delegated 1/

| | Percentage saying "some of my work could be performed by technicians and persons in other professions" | Percentage of all duty-time which could be saved through such delegation |
|---|---|---|
| Veterans Administration | | |
| Physicians | 27 | 7 |
| Dentists | 29 | 8 |
| Nurses | 55 | 24 |
| Public Health Service | | |
| Physicians | 29 | 8 |
| Dentists | 39 | 11 |
| Nurses | 46 | 16 |
| Army | | |
| Physicians | 46 | 17 |
| Dentists | 34 | 9 |
| Nurses | 54 | 19 |
| Air Force | | 20 |
| Physicians | 48 | 8 |
| Dentists | 23 | 22 |
| Nurses | 56 | |
| Navy | | |
| Physicians | 46 | 20 |
| Dentists | 34 | 9 |
| Nurses | 47 | 19 |

1/ These estimates are based on the personal judgments of respondents and undoubtedly are subject to some discount.

Among physicians, dentists and nurses in these five agencies from 23 to 56 percent said that some of their work could be delegated to others with less professional training or experience. According to their estimates from eight to 24 percent of all staff time could be saved by such delegation.

The Subcommittee does not feel competent to outline recommendations for specific steps in ancillary training. It does feel strongly, however, that the agency recommended herein for studies of personnel utilization must direct early attention to this problem and assist the various government agencies in developing additional training for medical assistants. It is recommended also that this agency determine the extent to which government jobs require personnel with unnecessarily high professional qualifications. It is becoming widely recognized, for example, that many nursing jobs in the non-federal field could be performed by sub-professional nurses with six to 12 months training, and there is much likelihood that nursing education will be reorganized to produce fewer graduate and more practical nurses. Wherever practicable, this method of separating jobs into their professional and sub-professional components is recommended for government agencies as an aid in reducing the gap between their personnel supplies and demands.

Miscellaneous Factors in Utilization. In the Armed Forces rank must be recognized as another barrier to proper assignment and economic utilization of personnel. A typical example is that of a request by one of the Armies for a specialist in preventive medicine. The replacement offered by the Surgeon-General was refused because his rank of

Colonel could not be absorbed in the T/O at Army Headquarters. Matching specialist qualifications with the job to be performed is difficult enough. When the additional necessity arises to match these factors with rank, especially in those fields where an Armed Force is unlikely to have more than a hundred men or so, it can be seen that a tendency is created either to stimulate morale problems or to lower utilization.

Further medical personnel are absorbed in quantity by methods of training and transfer. In the Army, requirements are computed on the basis that a medical officer assigned to an overseas theatre while on a tour of 24 months' duty will spend one month in the Basic Officers' Course and nearly four months in transit to and from his assignments.

Conclusions. While the Subcommittee is not prepared to state that the military agencies require too many physicians and dentists for discharge of their functions, as presently defined, it does believe that the value premises and the procedural methods which underlie calculation of such requirements have not been stated and explained with sufficient clarity to allow Congress or other agencies to form judgments as to their reasonableness.

It believes that the scarce skills of the more highly trained professional personnel can be more widely proliferated through increased use of ancillary workers.

It believes that proper assignment and effective use of the duty-time of professional personnel are often inhibited by rules and regulations which have grown rigid. This is especially indicated in the Armed Forces.

Inter-Agency Utilization

In addition to the possibilities within agencies for increased utilization of personnel, there is considerable opportunity to effect improvements by arrangements between agencies.

Studies in several metropolitan areas of the various federal hospital systems reveal serious duplication of facilities and the consequent waste of medical skills. In the New Orleans area, for example, the substitution for three small under-utilized military hospitals of local out-patient care, with hospitalization supplied in nearby installations of the Veterans Administration and the Public Health Service would reduce from 12 to three in this district alone the Army and Navy requirements for physicians. Additional supporting personnel now engaged in transport of soldiers and sailors needing general hospitalization to San Antonio and other distant points would also be conserved.

The Armed Services believe that joint staffing is at least a partial solution to personnel requirements. While the proposal to staff service hospitals through the joint use of Army and Navy personnel is approved in principle, it is believed that medical services which support the primary missions of the agencies of which they are a part cannot be merged or unified to a degree greater than the merger or unification which exists within these agencies as a whole. Joint staffing by subordinate agencies, in the absence of operational integration between the primary agencies, must be recognized as a measure of expedience rather than a lasting solution to problems of duplication, and cannot be expected to result in significant savings of personnel.

There is no feasible way of determining the location and extent of all opportunities for conservation of personnel through increased coordination of agencies. Therefore we cannot estimate total savings, either for the military and non-military services separately or for all federal agencies together. Voluminous data concerning instances of duplication are available but they cannot be added to an over-all figure for total federal savings. The existence of such data even in fragmentary form, however, such as those provided by the area surveys, forces the conclusion that the government as a whole is asking society to provide an increased share of its medical personnel resources without having organized its own services to achieve a desirable level of utilization of the personnel it already employs.

Incentive Pay in Army and Navy

In 1947 the pay of regular and volunteer Armed Force medical and dental officers was increased by $100 a month as a recruitment incentive. It was rationalized on the basis that the post-graduate training of these officers represented an investment not made by officers of the line. The effects upon recruitment are regarded as disappointing, even though Army and Navy attribute perhaps three or four hundred of their recent medical and dental volunteers to this measure. Effects upon resignations may be considered as being more substantial than new recruitment, however. The Armed Forces interpret their evidence to indicate important decreases in resignations and assume that an undeterminable but considerable number of physicians and dentists would have resigned from service if this additional pay had not been granted. Although the disparity between salaries of medical and line officers is recognized as creating morale problems in the service, it must be assumed that withdrawal of the present incentive pay would seriously undermine the Armed Forces' already weak reserve of experienced personnel and would bring further voluntary recruitment to a virtual standstill. (See Appendix 11.)

Medical Caste in the Military Services

Medical service in the Army and Navy tends to be divided into two spheres. Because of its relatively greater opportunities for advancement in rank or professional prestige, duty in the Offices of the Surgeons General, in general hospitals, and in the larger station hospitals in the Zone of the Interior is much preferred to duty in the smaller hospitals, in dispensaries and in personnel centers, or to duty overseas. Because of their lower rank and inexperience, ASTP and V-12 officers tend naturally to be utilized in the less attractive positions. It is these positions, which will soon be vacated, for which the services are unable to recruit volunteers.

Some of the measures undertaken for recruitment, and most especially the residency training programs, serve to procure personnel in large part merely to the degree that such personnel are assured of remaining on duty in the more attractive positions. When, upon completion of residency training, it becomes necessary to transfer these men to station hospitals and dispensaries, we must assume they will tend to react as service regulars do. The latter must be assigned by the Army and Navy with extreme care to prevent their resignation. It then can be assumed that the residents will accept their new assignments largely, if not only, because they will be under obligated service and may be expected to resign when their obligation has been discharged. In the meantime they will doubtless to a great extent have served with the same dissatisfaction as that registered by ASTP and V-12 officers and others who give professional service in repayment of a debt. There is no evidence that such obligated service, in the military forces or in civilian life, has given adequate satisfaction.

The military services are thus seen to be divided into two types of duty, one which is sufficiently acceptable to attract young physicians who desire training and other volunteers, and one which is so unattractive that unusual forms of pressure must be exerted to secure the necessary personnel, from within as well as from outside the service. Present measures undertaken and proposed may result in adequate staffing for the first type of duty but no method has yet been suggested which would staff an overseas dispensary, for example, with volunteer physicians. The necessary conclusion is that the homogeneous medical corps, staffed with career men and other volunteers, is a thing of the past and that the problem now faced is one of maintaining standards of medical care with a corps which is "half slave and half free".

Comments by ASTP and V-12 physicians obtained as part of the Subcommittee survey (See Appendix 50) outline a wide chasm between them and the regulars. Instead of the teacher-pupil relationship they had found in medical school, and the father-son relationship they know to exist between the older and younger physicians in civilian practice, these men find themselves separated from their elders in the Army and Navy by many barriers. Communication is inhibited by differences in rank, and professional differences of opinion are frequently settled by the authority of rank. Social distances are great. With one group obligated and temporary and the other voluntary and permanent there is little identity of objectives. The young officers feel they have no one upon whom they can lean, and the older men, frequently with the feeling that their subordinates are no more than "draft-dodgers", feel they have no one upon whom they can depend.

In view of this evidence that the mixture of volunteer and obligated service physicians creates a variety of frictions which might threaten the quality of medical care, and on the assumption that the necessity to have both types of physicians cannot now be avoided, it becomes essential that the military services make all possible reductions in their workloads so that the proportion of obligated and drafted personnel will be held to the very minimum.

Personnel Planning and Allocations

No agency or office exists which is authorized and staffed to study the needs for medical personnel of the government as a whole, to devise methods for improvements in assignment and utilization, to relate the requirements of one agency to those of another, nor to relate the needs of all to those of the rest of the nation. While the Budget Bureau has legal authority to question agency requirements, it does not undertake long-range planning and analysis of basic problems in personnel management. Neither have these functions been discharged by the Civil Service Commission, which has proved inadequate, insofar as the more highly professional medical personnel are concerned, even in its more standard functions of recruitment, examination and classification. Theoretically, the newly organized medical section of the National Security Resources Board will meet some of the needs for central planning, coordination and personnel research, but it is doubtful that its mission will be interpreted to include all of them, nor is it properly organized to do so.

Differences in the various systems with respect to pay, promotion, classification, retirement and other matters have grown so complex as to defy inter-agency comparisons. At a time when medical personnel are in short supply throughout the nation as well as in government, however, the need for standardization of such administrative policies is of secondary importance to the need for coordinated efforts to hold total federal requirements to the minimum. In general, each agency negotiates independently with medical schools and other sources of supply and makes independent arrangements, both inside and outside of government, for

the training of needed personnel. Coordinated approaches to these problems, and to other problems such as transfer or interchange of personnel, are inhibited by the lack of organizational structure bridging the different agencies and by the non-existence of a central record system which would make it possible to analyze the current status of medical personnel. At present it is impossible, without lengthy and intensive research in the various agencies, to know how many physicians, dentists and nurses are employed by government, what qualifications they have, where they are, what they are doing and how fully they are utilized.

Information of this nature within the central headquarters of the agencies themselves seems also deficient or ill-adapted for purposes of personnel planning. This is due apparently to a number of reasons.

Constant shifts in emphasis between centralized and decentralized administration results in record system changes which destroy continuity of data and defeat efforts to understand the trends and dynamics of personnel situations. The present emphasis on decentralization in the Army, for example, precludes intimate knowledge in the Surgeon General's office of factors affecting personnel overseas and in the field, and tends to reduce central personnel operations to a mechanistic process. Arbitrary, uninformed instructions by line command to discontinue or alter report forms are also said in the Army to have limited the planning functions.

Personnel planning is also frequently inhibited by the use of staffs who are trained and oriented to deal with individual records of persons rather than to analyze grouped data for findings of broader significance. In certain agencies personnel officers and technicians were found to be using laborious manual procedures through lack of knowledge concerning methods for exploiting their own punch card systems which carried the same data.

A central planning agency would facilitate the standardization of the various medical personnel accounting systems and thereby would more fully acquaint government with the effectiveness of its utilization and the actual extent of its requirements.

In time of war it is an accepted procedure to handle problems of personnel and materiel shortages by establishment of an office with power to determine how the production of such resources should be stimulated and regulated and how they shall be distributed among all users, governmental and civilian. This procedure does not necessarily require a war as justification, however, since shortages in material and human resources can be the cause, rather than the effect, of emergencies which endanger the welfare of the nation. Such an emergency now exists through inadequacy of the supply of medical and health personnel to meet demand, and it is recommended that a government agency be empowered to study the factors affecting production and utilization of this personnel, to make recommendations for adjustment of these factors, and to determine and regulate the personnel requirements of the Federal Government and of its separate departments.

It is believed that the National Security Resources Board, with its present organization and mission, cannot perform these functions. (See Appendix 17, msc-65.) It lacks authority to allocate personnel; its mission is focused primarily upon planning for war and places only a secondary emphasis upon attention to problems of peace-time emergencies; and its membership includes department heads who are interested parties to the problem of personnel procurement.

Properly to perform the function outlined, the program of the agency recommended should meet among others the following four conditions:

1. It must contain power to establish ceilings upon personnel in the various government agencies. Legally the Budget Bureau now has such authority but it has neither the tradition nor the staff to investigate in scientific fashion those questions of personnel supply and utilization which must underlie allocations. Its reductions of departmental requests are more likely to be based on the assumption that such requests are normally inflated rather than upon the expert study needed for informed judgments.

2. The agency must make its determinations upon the basis of its own direct studies of personnel utilization and requirements in the various federal health and medical care programs, and not, as the National Security Resources Board, rely upon data furnished by the departments conducting such programs.

3. It must be directed by persons who themselves have no responsibility for nor direct interest in the management of any medical or health service program, in or out of government. Studies of the character required in a program for allocation of medical personnel are

dependent in the extreme upon good professional judgment. Over and above this quality evaluation, however, is the importance of objectivity. In manpower problems involving professional or highly technical personnel precise measures of output are lacking. Determination of the relative essentiality of service to a given workload, or of the quantity of personnel needed to perform such service, must rest to a great extent upon those forms of value judgments which are usually warped by the bias of interested parties. This bias results in inflated personnel requirements and fosters the tendency of user agencies toward "empire building".

4. It must be a continuous program. Barring a drop in the economic level of the nation we must assume that medical personnel will be in short supply for at least another decade. After that time, in the interest of governmental economy and to safeguard against emergencies, we must assume that problems requiring conservation will either exist continuously or could arise upon short notice. In either case there is need for continuing study and planning. Valid and useful research in personnel supply, utilization and management is too complex to be started and stopped overnight. If it is either intermittent, or if it is focused too narrowly upon preparation for war or other specific emergencies, its usefulness is abridged.

Reorganization of any existing agency, or adaptation of any agency currently proposed, to discharge the function outlined above introduces several considerations.

If we are to assume that the Department of Health, Welfare and Security will itself be a substantially large employer of medical

personnel, its Secretary, as an interested party, would not be qualified to allocate personnel to other agencies.

If we assume there will not be extensive concentration of present medical care programs in the Department of Health, Welfare and Security, the function of personnel allocations becomes even more essential as a means of coping with the competitive requirements of a larger number of independent agencies, and the Departmental Secretary could discharge this function without question concerning his objective interest.

This arrangement, however, calls for serious consideration as to whether the conservation of medical resources should be identified with the problems of medicine or with the more general problem of scarce resources. The judgment of your Subcommittee is that, while it happens now to be extremely acute, the problem of medical personnel is kindred to many other problems of scarcity which exist or may arise in other fields. The organization needed now to cope with scarcities in medical personnel can likewise be relied upon to cope with the corresponding problems of other fields. We therefore approve of the program of the National Security Resources Board to this extent, namely, that its approach is to the scarcity of resources in all fields rather than to the various problems of selected fields. While the program of a general resources analysis and allocations agency is of no official concern to this Subcommittee except as a mechanism for approaching the problem of medical manpower, we do not recommend that this problem be isolated from those created by scarcities of other resources.

In view of the foregoing considerations, the Subcommittee recommends: Establishment of a resources analysis and allocations agency, whose director shall be responsible to the President, which will determine the material and human resources needed by government and by its several agencies and allocate such resources accordingly, and which will itself have no direct responsibility for operation, other than analysis or planning, which would employ or utilize such resources.

## Conclusions

Under the conditions of voluntary recruitment and retention of medical personnel, manpower is not available to federal agencies in amount sufficient for them to meet the responsibilities delegated to them for supplying medical service.

Vigorous efforts at recruitment, supplemented by intra-agency and inter-agency adjustments designed to provide more attractive conditions, greater rewards in prestige and pay, improved personnel management and career planning have failed to attain the desired objective.

Inter-departmental efforts of the Armed Forces to introduce Joint-staffing and other economies in utilization as directed a year ago by the Secretary of Defense have failed to reduce the demand for medical personnel so that it can be met by the supply available through voluntary recruitment.

Any and all measures proposed to obtain sufficient medical manpower, including the request for selective service authority presented to the 80th Congress, are judged inadequate to accomplish the objectives of the agencies if the assumption is made that federal medical service be of reasonable quality.

Measures that might be authorized by Congress to increase the supply of medical personnel in the nation as a whole, or that portion of supply that might by special inducements be diverted into federal service will be difficult to formulate, slow to put into operation, delayed in result and uncertain in action. This is an important subject for emergency sustaining measures and for long-range planning. (Recommendation attached)

The failure of the present arrangement to obtain the manpower essential to the task that the government has assumed requires either a reduction of the workload or a reorganization of the system of providing health and medical service, or, most likely, both measures.

Workload Reduction

An analysis of the workload of medical service, as it now exists, reveals large components that can be identified with primary functions of government only by the admission of ethical and "moralc" premises. For government to have assumed this workload may have been useful in the development of national life as a whole and may have been helpful to an agency in the discharge of its primary function. Particularly with reference to health and medical services, the development and preservation of national ideals may have been furthered. It is the method of carrying this extra workload, however, that must be measured against the ability of the nation to provide manpower for them under conditions that do not conflict with the preservation of national ideals that are weighted with even higher priority by the people.

Specifically, these components of the workload that are found on the boundaries of the function of government are: medical service to veterans with non-service connected disability other than those who are medically indigent; dependents of members of the armed forces; merchant seamen; and other miscellaneous groups of "supernumeraries."

To obtain medical personnel for this workload by measures other than voluntary recruitment tests the limits of authority in government against the boundaries of function in government.

The more closely the workload of medical service assumed by the armed forces can be identified with their primary function, the less will be the conflict in principles encountered by the use of compulsory service to obtain the requisite manpower.

Withdrawal of a portion of the existing workload of the armed forces would reduce their demand for medical personnel more effectively than any joint action they have devised. To provide service for this same portion of workload in a new agency along with other federal beneficiaries might even reduce the total federal demand for manpower. More important than any reduction in overall demand, however, would be the separation of an area supplied by voluntary recruitment from an area in which recruitment by authority, if need exists, can operate more freely.

Similarly, the area of voluntary recruitment might receive a flow of manpower for workloads now served by the military if unhampered by personnel policies and regulations designed basically for military agencies that accept recruitment by authority as a premise of function. These policies and regulations have been identified as a major barrier to recruitment within the agencies of the defense establishment.

An agency separate from the military can extend the use of part-time civilian physicians to actual participation in the treatment of patients and to the assumption of a portion of the workload of its hospitals. This is in contrast with the part-time consultant system

established by the Army and Navy that has utilized part-time civilians in consulting and teaching capacities.

At the present time the prospects of meeting the requirements for medical personnel for the armed forces to carry the existing workload are exceedingly bleak. It is believed that they will be improved only if a reduction of their workload can be accomplished. That any plan can be devised that will solve the procurement of manpower for federal medical service as a whole without reduction of the total workload is gravely doubted.

Reorganization

A. The National Military Establishment

The assumption that a medical department be organically incorporated in the armed force it serves will not be questioned.

Close identification of its medical personnel with those phases of health are medicine that are directly pertinent to the primary functions of the armed forces will require that existing motivations now linked with prestige and competence embracing the wide range of medicine and medical science be narrowed to motivations that are based on military medicine.

That this narrowed identification have an adverse effect on over-all recruitment of medical personnel for the armed forces is admitted.

Gains in over-all voluntary recruitment, however, insofar as they have been made at all, are visible only in those areas where prestige and attainments in the non-military aspects of medicine have been put forward deliberately to stimulate recruitment and while the strictly military functions were obscured. These military-identified functions, except in the top overhead, are now being carried by

personnel in obligatory service. There is no liklihood that voluntary recruitment can provide replacement.

It is recognized that the mixture of officers of junior rank on obligatory service with officers of senior rank on voluntary service, as it exists at the present time, produces a critical and undesirable situation.

A medical department organically incorporated in an armed force may rightly insist that its peacetime activities represent total medicine on the grounds that it is a skeleton organization that must provide total medicine in war. The peace-time workload of medical service, however, can likewise be skeletonized to that amount essential to the planning function and to clinical research on subjects of vital significance to the military establishment. Only a portion of the present heavy workload can be identified on any reasonable grounds with either planning or research pertinent to the primary function of the military establishment. It is valued for professional experience and prestige and as an inducement to recruitment. Continuation of the present state of affairs, therefore, actually threatens to divert the personnel of medical departments from meeting the primary responsibilities of the agencies withing which they are contained.

Reorganizational planning that envisions transference of that portion of the workload of the military medical departments that is not identified with the primary function of their agencies, must recognize that it is this component that is most highly valued by the medical departments themselves because it develops prestige and competence in the wide range of medicine. The medical departments that remain after such transfer can be assisted by making provision

for training and rotational privileges open to the military in any new agency. The extent of this opportunity, however, can be measured solely on the basis of its training value and cannot be determined by the magnitude of any workload transfer.

Attention is called to the fact that this workload component regarded suitable for transfer is exactly that component that is most difficult for the military to supply with acceptable quality medical service requiring, as it does, specialist services that cannot be obtained by obligatory service requirements.

B. Reorganized Agency for Medical Service

By consolidating components of the workloads of several agencies into one agency, certain savings in the demand for medical personnel may be achieved as already indicated. The consolidation of a series of deficits, however, does not yield a positive balance. The workload must be ultimately be brought into balance with the manpower available.

Incentives to personnel procurement on a voluntary basis must be provided if existing difficulties are to be overcome.

The competitive pressure exerted by non-governmental medical practice demands that the pay schedules of government physicians approximate the range of the financial opportunities of non-governmental practice.

Special incentives will be required to secure physicians of outstanding ability.

A high level of professional leadership will be essential both to maintain standards of quality in the medical service provided and as a procurement incentive for physicians who place great

emphasis on opportunities for training and professional growth.

Laws and regulations governing personnel assignment, salary and promotion must be sufficiently flexible to recognize professional experience and competence.

From the top to the operational level, an organizational plan of government medical service must integrate itself with the structure of non-governmental medicine.

## SUPPLEMENT A

### Balance Sheet of Physician Procurement in Armed Forces

At the present time there appears to be no method by which the Armed Forces can staff their medical services entirely by volunteers. Before other forms of obligated service are utilized, it is recommended that physicians who participated in the ASTP and V-12 programs and who have not served on active duty be called to duty in the Armed Forces as needed.

On 31 October 1945 there were in ASTP 1,387 freshmen, 892 sophomores and 2,500 juniors, a total of 4,779. The Army estimates that due to various types of attrition only 3,000 would be available for service, 2,000 in 1948 and 1,000 in 1950. The Navy estimates there are now 3,750 V-12s who have graduated and 1,250 who would be available, less attrition, in 1950. Availabilities in these V-12 groups are estimated at 80 percent.

On the following page it is shown that the combined deficits of physicians as of 30 June 1949 are predicted at 4,795. Assuming that 5,000 ASTP and V-12 men could be procured, and that direct Air Force recruitment would produce an additional 100 men, this deficit would be met and a small reservoir of 305 would remain. Assuming 2,000 additional ASTP and V-12 men would become available in 1950, numerical adequacy of medical staffs would be assured until 1951 or 1952 when the entire problem would again have to be faced.

This reservoir of personnel could be conserved for several years more if the Armed Forces were relieved of responsibility for general

## APPENDIX A

### Lower Effect of Unreliable Procurement in Model Uniform

[illegible]

Balance Sheet of Federal Physician Procurement
as of 30 June 1949

ARMED FORCES

| | Army and Air Force | Navy | Total |
|---|---|---|---|
| Deficits Predicted by Services a/ | 3,068 | 1,727 | 4,795 |
| Less Savings by Reduction of Workload b/ | 1,490 | 1,495 | 2,985 |
| General Hospitals | 1,250 | 1,385 | 2,635 |
| Discontinuance of Care for Dependents c/ | 100 | 140 | 240 |
| Removal of Other Requirements d/ | 1,150 | 1,245 | 2,395 |
| Station Hospitals and Dispensaries c/ | 240 | 110 | 350 |
| Discontinuance of Care for Dependents | 235 | 110 | 345 |
| Removal of Care for Veterans Administration Beneficiaries | 5 | — | 5 |
| Net Armed Forces Deficits | 1,578 | 232 | 1,810 |
| Less Additional Personnel Gains | 2,100 | 3,000 | 5,100 |
| Independent Air Force Recruitment (Not Additional) | 100 | — | 100 |
| Procurement of ASTP and V-12 Physicians e/ (1949) | 2,000 | 3,000 | 5,000 |
| Surplus in Reservoir (1949) | 522 | 2,768 | 3,290 |
| Procurement of ASTP and V-12 Physicians e/ (1950) | 1,000 | 1,000 | 2,000 |

a/ Estimated on basis of requirements for a troop strength of 1,335,000 for the Army and Air Force and 592,000 for the Navy.
b/ Assumes a reduction of workload in the Continental United States only.
c/ Consists of estimated requirements for current experience.
d/ Includes requirements for Veterans Administration beneficiaries and for station type care of Army, Air Force and Navy personnel located in stations adjacent to general hospitals.
e/ Availabilities estimated by Army and Navy.

hospital service, where physician requirements are stated to be 2,635. If in addition the care for dependents in the continental United States and for veterans were discontinued by the Armed Forces an additional 350 physicians, or a total of 2,985, would not be required. This would lower the combined deficit to 1,810, which could be covered by next year's procurement. This would leave a surplus in the reservoir of 3,290 in 1949 or, counting the 2,000 ASTP and V-12 men who will complete their residency training in 1950, a surplus of 5,290.

It is necessary to assume, however, that the present general hospital systems would not be removed in their entirety from the Armed Forces but that each Arm would have a medical center, which would require staffing. Moreover, it is assumed that the Services would make arrangements to keep a number of their personnel in training in federal and private hospitals and schools. Due to these requirements for personnel, the surpluses computed above would have to be reduced in proportion.

[illegible]

[illegible]

[illegible]

[illegible]

## SUPPLEMENT B

## Federal Aid to Medical Schools

Purpose: To maintain and increase the supply of health, medical and medical research personnel as a national asset.

Recommendations:

1. Authorization and appropriation of an interim program of educational grants for medical education and grants for dental, nursing and public health education similar to provisions of Sec. 372, S. 2588* introduced April 30, 1948 by Mr. Thomas, but with following changes:

(a) Limitation of authorization to a three-year program

(b) Reestimation of amounts, particularly with reference to schools of nursing

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* Sec. 372. In order to enable the Surgeon General, through grants to schools, to assist in increasing the number of individuals adequately trained in the fields of medicine, nursing, dentistry, and public health, there are hereby authorized to be appropriated (a) for grants to schools of medicine, $18,000,000 for the fiscal year ending June 30, 1949, $20,000,000 for the fiscal year ending June 30, 1950, and for each fiscal year thereafter such sums as may be necessary; (b) for grants to schools of nursing (both graduate and undergraduate), $15,000,000 for the fiscal year ending June 30, 1949, $18,000,000 for the fiscal year ending June 30, 1950, and for each fiscal year thereafter such sums as may be necessary; (c) for grants to schools of dentistry, $6,000,000 for the fiscal year ending June 30, 1949, $8,000,000 for the fiscal year ending June 30, 1950, and for each fiscal year thereafter such sums as may be necessary; and (d) for grants to postgraduate schools of public health, $1,500,000 for the fiscal year ending June 30, 1949, $2,000,000 for the fiscal year ending June 30, 1950, and for each fiscal year thereafter such sums as may be necessary. Grants to any school from appropriations under this section may be used by such school for the establishment and maintenance of its staff and the maintenance and operation of its facilities (including the acquisition of equipment).

2. Authorization of a continuing program of educational grants on basis of:

(a) A survey phase for which appropriation is made, followed by:

(b) Subsequent appropriations based on findings of survey.

Summary:

Need for emergency legislation as interim measure based on current deficits of educational institutions and the consequent reduction in output of physicians and other personnel which is imminent.

A survey phase in the more prolonged program for which authorization is requested is required to establish extent of need and methods of administering subsequent appropriations. This survey to determine:

1. Grants for construction designed to increase output by new facilities or by replacement of obsolescent facilities;

2. Grants for salaries of teaching staffs, and for other professional and administrative staffs;

3. Measures to relieve educational institutions of financial burden of community medical service which is necessary but not primary function in medical education. Grants to teaching hospitals;

4. National scholarship program without harassing conditions of obligatory government service (except in national emergency) that might reduce output of specialized and research personnel;

5. National fellowship program for post-graduate education of physicians and other personnel in medical science.

## SUPPLEMENT C

### Additional Aid to Medical Education

To afford an opportunity for the study of medicine, dentistry, nursing and public health to the students who are best qualified, it is recommended that the program of federal aid to medical education make provision for scholarships and fellowships.

Although three-fourths of the cost of a medical school course is not borne by the student, the portion which he does bear has increased so rapidly as to deny medical education to all but the members of relatively well-to-do families. Tuition and living costs during the four-year course have an estimated range of $5,000 to $10,000. This does not take into account the costs to each person of pre-medical and internship years.

The effect of this condition is to narrow the field of applicants from which the medical schools may draw students and thus, for financial reasons alone, cause the schools to admit students with lesser qualifications than others.

Many and varied suggestions have been made as to the types of scholarships and fellowships which should be established by the federal government. While your Subcommittee feels that the specifications for long range scholarship and fellowship programs must be determined by the study previously recommended of the broad problem of grants to medical schools, it does not believe that initiation of these programs need await the results of that study. In keeping with the plan to extend interim aid to medical schools in the immediate future, we believe in the simultaneous creation of limited numbers of scholarships and fellowships.

A suggestion commonly made concerning federal scholarships is that they be conditioned upon agreement by medical schools to increase current enrollment by the number which corresponds to the number of scholarships. As a means of increasing the supply of physicians in the country this suggestion is approved in principle but it is believed that such a condition, if rigidly adhered to, might interfere with administrative freedom in the schools or might otherwise work hardships on them. Without further and careful consideration this condition could not be recommended.

Under a bill recently introduced in the Senate (S. 2588, Mr. Thomas of Utah) it was proposed that the government should grant medical scholarships to the various states on the basis of population, with freedom for the scholars to apply for admission to the schools of their choice. It might be more to the nation's interest if these scholarships were awarded to and through the states in some proportion to their local needs rather than according to population. This principle, which is followed to some extent in application of the Hill-Burton Act for hospital construction would tend to compensate for the serious maldistribution of physicians. Some states have less than a third as many physicians as others in proportion to their populations, and this disproportion has been increasing rather than decreasing. Since young physicians from rural states and areas tend to return to their homes to practice, and since those from urban areas very seldom seek practice in the more rural areas, this factor of residence calls for consideration in drawing up specifications for scholarship programs.

This principle cannot be followed without regard to a number of other factors, however, notable among which is the possible threat to the quality of the student body, and no specific recommendation concerning this approach is made at present.

Another possibility which calls for consideration is the "school-leaving scholarship" which is used in England and has been tried at Haverford College in Pennsylvania. Under this method the government scholarships would not be awarded by the states or by medical schools but by the universities and colleges giving premedical training, each of which would be allowed one or more scholarships. One advantage claimed for this scheme is that students are selected by their own faculties and thus by the persons most intimately familiar with their academic qualifications and personal caliber. Another advantage claimed is that this procedure tends to create a healthy competition among medical schools for such carefully selected personnel.

These and many other considerations call for further study before patterns of government scholarship and fellowship aid are permanently established, but it is the feeling of your Subcommittee that the present situation justifies an immediate beginning of aid, and moreover that the experience to be gained from such a beginning is essential to the fuller study of the problem which is to determine these permanent patterns.

## SUPPLEMENT D

### Summary of Recommendations

1. That the federal government meet the manpower demands of medical service that are clearly identified with the primary functions of the National Military Establishment by obligatory service if and when necessary.

2. That physicians and dentists who participated in the ASTP and V-12 programs and who have not been on active duty with the military services be called to duty as necessary and that other physicians and dentists shall not be obliged to serve until this reservoir of personnel has been exhausted. (Supplement A, Page 136.)

3. That all components of the workload of federal medical service, including those now assumed by the Armed Forces but not clearly identified with their primary missions, and excluding those which are so identified, be consolidated in a single agency.

4. That the workload of this agency be adjusted to meet limitations in the procurement of medical manpower by voluntary recruitment.

5. That all federal procurement programs for medical personnel be centralized in this agency except those of the National Military Establishment; and that the procurement programs of the Armed Forces be coordinated or unified in the Office of the Secretary of Defense to the maximum extent feasible.

6. That an agency be created or empowered to study the medical personnel requirements of the federal government and to allocate the supply available to the various departments and agencies on the basis of such study. (Pages 125-128.)

7. That this analysis and allocations agency study the use in government of ancillary medical personnel and make recommendations which will serve to maximize such use. (Pages 109-114.)

8. That federal aid be extended to schools of medicine, dentistry, nursing and public health (Supplement B, Page 139), and that students of these schools be aided through federal scholarships and fellowships. (Supplement C, Page 141.)

NOTE: Appendix material which supports this report and to which reference is made throughout the report consists of approximately 350 pages of manuscript. A master copy is on file in the offices of the Medical Services Committee but is not being reproduced at this time.

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